



NHS FUNDED NURSING CARE IN CARE HOMES IN ENGLAND: AN INITIAL ASSESSMENT

FINAL REPORT

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CONTENTS

	Page no
CONTENTS	i
ACKNOWLEDGMENTS	iii
 CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY	1
1.1 PURPOSE OF THE STUDY	1
1.2 ADVISORY BOARD	2
1.3 OVERVIEW	3
 CHAPTER 2: STUDY DESIGN	12
2.1 OVERVIEW OF STUDY	12
2.2 STAGE 1 STAKEHOLDER INTERVIEWS	13
2.3 STAGE 1 POSTAL SURVEYS	15
2.4 STAGE 2 POSTAL SURVEYS	22
2.5 STAGE 3 LOCALITIES STUDY	25
2.6 ETHICAL CONSIDERATIONS AND DATA PROTECTION	29
2.7 MODIFICATIONS TO ORIGINAL PROPOSAL AND THEIR RATIONALES	30
 CHAPTER 3: FINDINGS FROM STAGES 1 & 2	33
3.1 INTRODUCTION	33
3.2 EARLY IMPLEMENTATION OF NHS FUNDED NURSING CARE	34
3.3 PROGRESS AND RESOURCES REQUIRED FOR DETERMINATIONS	54
3.4 RNCC DETERMINATION PROCESS	64
3.5 OUTCOMES OF RNCC DETERMINATIONS	80
3.6 ORGANISATIONAL IMPLICATIONS OF NHS FUNDED NURSING CARE	92
3.7 CONTINENCE AIDS/ SPECIALIST EQUIPMENT	103
 CHAPTER 4: FINDINGS FROM STAGE 3: IN-DEPTH QUALITATIVE STUDY	112
4.1 INTRODUCTION	112
4.2 METHOD STAGE 3	114
4.3 RESULTS: PROFESSIONAL THEMES	121
4.4 RESULTS: THEMES FROM SERVICE USERS' PERSPECTIVES	149
4.5 SUMMARY OF FINDINGS FROM STAGE 3	157
 CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS	158
5.1 5.1 CONTEXT	158
5.2 5.2 MAIN MESSAGES FROM STUDY	161

REFERENCES	180
ANNEX 1	189
ANNEX 2	190
ANNEX 3	195
ANNEX 4	201
ANNEX 5	203
ANNEX 6	209
ANNEX 7	211
ANNEX 8	219
ANNEX 9	223
ANNEX 10	225

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Study Team

The study team members are shown below together with their contribution to the research:

- **Professor Ala Szczepura** Centre for Health Services Studies (CHESS), University of Warwick: *Responsible for co-ordination of project and final report writing.*
- **Carol Davies** Centre for Health Services Studies (CHESS), University of Warwick: *Responsible for overall conduct of project, development of stage 1 and stage 2 national survey questionnaires, data analysis and final report writing.*
- **Deidre Wild** University of the West of England (previously RCN) *Responsible for co-ordination of project, literature review and final report writing.*
- **Isabelle Johnston** Royal College of Nursing (RCN) London: *Responsible for national stakeholder interviews, conduct of one locality study, and contributed to development of survey questionnaires and to final report writing, and professional nursing advice.*
- **Deborah Biggerstaff** Centre for Health Services Studies (CHESS), University of Warwick: *Responsible for conduct of one locality study, analysis of stage 3 qualitative data, and final report writing.*
- **Pauline Ford** Royal College of Nursing (RCN) London: *Contributed to final report writing.*
- **Yana Vinogradova** Centre for Health Services Studies (CHESS), University of Warwick: *Contributed to statistical data analysis.*

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 PURPOSE OF THE STUDY

1.1.1 Aim

- The overall aim of this study was to provide research evidence on the implementation of NHS funded registered nursing care in care homes.¹

The research focused on the first phase of implementation of NHS Funded Nursing Care (FNC), i.e. the Registered Nursing Care Contribution (RNCC) determinations for existing and new self-funding residents. These were to be completed by 1st April 2002 by Primary Care Trusts (PCTs) and, where PCTs were not fully operational, by Health Authorities (HAs). The evaluation started after the end of this period, and was completed in as rapid and robust a manner as possible.

In the course of the evaluation some data were inevitably collected on the second phase of the implementation of NHS FNC, i.e. after 1st April 2002 any person who became a resident in a care home was to have a RNCC determination carried out prior to placement, and by April 2003 determinations were to be completed for all existing local authority (LA) supported residents.

1.1.2 Objectives

Within the overall aim described above, the study had a number of objectives:

- to examine the use of the RNCC tool in the field, including its acceptability to registered nurses, the number of RNCC determinations undertaken for existing self-funding residents, the perceived consistency of decisions made across a range of bands within HAs/PCTs, and the need for modification of the tool based on national use in the field;
- to identify the number of appeals against RNCC banding decisions, and to examine the reasons for these appeals and their outcomes;
- to estimate the nurse resource implications of the first phase of implementation, including performance and monitoring of RNCC determinations and conduct of appeals; and to identify other resource implications in terms of the number of residents requiring funding for continence promotion aids and specialist equipment;

¹ Throughout this Report the term 'care home' covers both nursing homes, residential homes, and 'dual registered' homes (Care Standards Act, 2000).

- to identify the views of a cross-section of registered nurses (RNs) and managers working in independent care homes of the RNCC determination outcomes for their residents;
- to provide an initial assessment of the impact of implementation of NHS funded nursing care on the relationship between the NHS and care homes.

1.2. ADVISORY BOARD

An advisory board met three times during the study to assist with the development of the research project and commented on some of the early findings as well as giving ongoing guidance. The group composition is shown in Table 1.1.

Table 1.1. Advisory Board Members

Ms Carolyne McKinlay	General Manager	Thames Valley HA
Ms Sandra Betterton	Head of Nursing	Norfolk, Suffolk & Cambridgeshire
Ms Mary Goward	Nursing Lead Nurse	National Pensioners Convention
Mrs Joan Hall	Chair	National Pensioners Convention
Mr Ian Ireland	Care Services Quality & Development Manger	BUPA
Mrs Sharon Blackburn		Elizabeth Finn Trust
Mrs Ann McKay	Director Community Care	Independent Healthcare Association
Dr Laxman Nayak	Director 1000 Elders	Centre for Applied Gerontology, University of Birmingham
Mr Jonathan Ellis	Policy Director	Help the Aged
Heather Wing		National Care Standards Commission
Tricia Davies	Director of Corporate Policy and Communications	National Care Standards Commission
Professor Janet Askham	Director Institute Gerontology	King's College
Mrs Sue Humphries	Chief Executive	Morris Care Division
Deborah Sturdey	Nursing Advisor	Department of Health
Mr John Crook		Department of Health
Professor Alison Kitson		RCN Institute
Ms Pauline Ford		RCN Institute

1.3. OVERVIEW

As a result of the Government's review of health care services, stemming from the NHS Plan (DoH 2000 a) and the Government's response to the Royal Commission (1999) on long term care, a major structural re-organisation was underway in the NHS during the period covered by this study. As part of the re-organisation, individual general practices, which had previously been organised into Primary Care Groups (PCGs) representing local areas, were amalgamated into larger geographical areas as PCTs (DoH 2001 a). The first tranche of PCTs were established in October 2001 and the second became operational in April 2002. In addition, the boundaries for HAs changed and designated Chairs and Chief Executives were appointed to new, larger Strategic Health Authorities (SHAs), which became operational in October 2002. At the same time, PCTs formally took on all their new functions, including joint responsibility for health and social care. By March 2003, the abolition of NHS Regional roles also had largely taken place. A lead PCT within each SHA now commonly holds responsibility for commissioning of services with local providers, and designated PCTs are responsible for training and research, and their respective budgets. In addition other changes affecting health and social care for older people were outlined in *The National Service Framework for Older People*, (DoH 2001 b), and for independent sector care homes with the advent of the National Care Standards Commission, responsible for monitoring and enforcing the 38 National Care Standards (DoH 2002 a).

The National Service Framework for Older People (DoH 2001 b) outlined an ambitious strategic ten year plan for the health of older people. Its key aims and standards are: to improve access to services and to eradicate ageism; to implement a person-centred approach towards older people: to include older people in decision-making related to their care and through their representation within NHS committee structures. It also formed the basis for successive policy for the reconfiguration of services and funding to include an intermediate care provision (DoH 2001 c) that incorporates the use of independent sector facilities; and to ensure more consistent funding and partnership working for long term care (DoH 2001d). In addition, the multi-agency single assessment process (SAP) for all older people was introduced from April 2002 (DOH 2001 e). Although this process is for older people, guidance for assessment of other adults is also provided, for example in *The National Service Framework for Mental Health* (DoH 1999).

On 1st April 2002, the National Care Standards Commission (NCSC), was set up by the Government as an independent body to enforce 38 National Minimum Standards in care homes in England (DoH 2002 a). This represented a major change for independent sector care homes in England in addition to the introduction of NHS FNC towards the end of the previous year. The standards cover a range of requirements from the size of residents' rooms and width of doorways, to the recording of pressure sores and the provision of a care plan for every resident. The standards also set out the minimum levels of equipment that care homes should provide, including continence promotion aids. Inspectors from the NCSC make two visits a year to every care home (one planned and one unplanned) in order to check that

standards are being met. Care homes are allowed to phase in changes requiring major structural alterations gradually over 5 years. Following a Government review of the standards for care homes for older people (DoH 2002 a), in February 2003, amendments were made to certain environmental standards (DoH 2003 a). These meant that existing care homes (prior to 2002) would no longer be expected to meet some of the environmental standards that came into force on April 2002.

In the midst of this climate of major change, the Government committed itself to funding registered nursing care for all, regardless of the setting in which it is delivered (DoH 2000 a), para. 15.18). This meant that from October 1st 2001, the NHS would pay for the care given by registered nurses in care homes in England following an RNCC determination. This element of nursing care was to be funded centrally for care home residents and was implemented in two distinct stages (DoH 2001 f).

During the first phase, all self-funding residents in care homes were to have their level of registered nursing care need decided through the use of the RNCC determination tool, and appropriate NHS funding, determined by one of 3 bands, was to be provided for this element of their care. For all self-funding individuals in residence before 1st October 2001 (existing residents) a first determination was to be completed by a NHS registered nurse before 31st December 2001, and for those admitted subsequently (up to end of March 2002) a determination was to be carried out as soon as possible. It was also stipulated that all permanent residents should have their registered nurse care needs reviewed within 3 months, and then on an annual basis, or earlier if there was a significant change in health status (DoH, 2001 f).

During a second phase (after 1st April 2002) anyone entering a care home for non-urgent nursing care was to have a determination of care carried out; and from 1st July 2002, a target was set that this should be completed within 2 weeks of the need being identified. From 1st April 2003, local authority supported residents in nursing homes were also to receive NHS FNC and NHS funded continence products and equipment, rather than from the local authorities. Thus, from April 2003 the funding of registered nursing care for some 85,000 care home residents transferred from local authorities to the NHS. Furthermore, from April 2004 (DoH 2002 b) anyone entering a care home is to receive a single joint assessment and a determination of care carried out by a NHS registered nurse prior to placement; the date was put back following initial guidance for SAP.

The initial term 'Free' nursing care has led to some confusion because the NHS FNC, designed to meet the cost of registered nursing care, excludes any resources required for personal care. However, when registered nursing care needs are judged to be substantially greater than the RNCC high band funding and individuals require continuous registered nursing input, residents are entitled to receive Continuing Care funding where all nursing care costs are met by the NHS (DoH 2001 g; DoH 2003 b)

The RNCC determination is based on the following definition of nursing care in a care home, as given in the Health and Social Care Act, 2001. In this, nursing care includes *"services provided by a RN and involving either the provision of care or the planning, supervision or delegation of the provision of care"* for the resident in the care home setting. It does not include *"any time spent by any other personnel, such as care assistants, who may also be involved in the provision of care, but would include the nurse input for monitoring care delegated to others"*. The situation in the care home sector contrasts with the provision of nursing care in other parts of the NHS (also delivered by a mixed workforce of RNs and health care assistants, and where the latter are under the supervision and management of the RN). This care is currently funded through central sources for both community nursing services and acute medical services, and may include personal care. The perceived discrepancy resulted in considerable media coverage during the consultation period prior to implementation of the new FNC initiative, with specific points being raised by bodies such as the NHS Confederation, the Royal College of General Practitioners (RCGP), the Royal College of Nursing (RCN), Age Concern, the Registered Nursing Home Association (RNHA), and the Independent Healthcare Association (IHA); and more recently in the report of issues arising from complaints by the Health Service Ombudsman (2003).

From October 1st 2001 continence products were also to be made available by the NHS to all residents of care homes who receive NHS funded care, following an continence assessment (DoH 2001g). For new entrants to care homes, the assessment would inform the continence status within SAP. Continence advisors, nurses and PCTs were advised to use the period up to April 2003, *'to establish processes for continence assessments of needs currently funded by LAs and prepare themselves for providing continence services for all those in nursing homes in assessed need of services from 1st April 2003'* (DoH, 2001 f). In terms of equipment, following earlier direction (DoH, 2001 h) the Department of Health has issued further guidance in support of FNC (DoH, 2003 d). For, whilst care homes provided much of the care equipment required, and some equipment was obtainable by prescription, it was acknowledged that following appropriate assessment, care home residents should have access to the full range of specialist NHS support and equipment available through community equipment services (DoH, 2001 f; DoH 2001 h; DoH 2003 c, DoH, 2003 d, DoH 2003e) In August 2002, guidance for integrating community equipment indicated that £11.7 million was given for the NHS in the 2001/2002 baseline allocations to HAs, and around £28 million and £64 million would be allocated in 2002/2003 and 2003/2004. Respectively (DoH 2003 e).

1.3.1 Implementation process for FNC

As explained above, in October 2001 FNC was implemented for care home residents in England (primarily older people, although all adult residents are included) who were self funding their care (DoH, 2001 f). Other changes in NHS and local authority responsibilities for self-funders and supported residents were also detailed. The transition period for managing these major changes was October 2001 to

March 2003. As part of the implementation process, a training programme was initially set up for key regional nurses at the DoH. These key regional leaders were then responsible for identifying and training lead nurses from HAs/PCTs, who would then cascade-train the RNs designated to carry out determinations. A practice guide and workbook on NHS Funded Nursing Care had been provided by the Department of Health (August 2001) and was available on the internet (DoH, 2001 i) . Public information leaflets for residents, families and carers, were also provided by the Department of Health to HAs and local councils for distribution to care homes, explaining FNC changes (DoH, 2001 j).

1.3.2 Human resource strategy for FNC

In preparation for phase one implementation, PCTs, and where these were not fully operational HAs, were requested to have in post prior to October 2001: (i) *a nursing home co-ordinator (the budget manager)* whose role would include management and monitoring of the budget for NHS funded registered nursing care; liaising with local care homes, social services and nurses carrying out determinations; and acting as a focal point for any complaints; and (ii) *a lead nurse* to provide professional nursing advice to care homes about the conduct of determinations; monitor the quality and consistency of RNCC determinations carried out by RNs in the HA/PCT; and oversee training of these RNs; or one person *combining both roles* (DoH, 2001 f)

Subsequent draft guidance issued for FNC in 2002 (DoH, 2002 b) suggested that, because lead nurses have responsibility for RNCC audit, they should either not undertake RNCC determinations themselves within their PCT boundary, or, in circumstances where they do so, a neighbouring PCT should undertake the auditing role. The audit tool for the quality of RNCC determinations was made available on the Department of Health's website (DoH 2002 c).

Early indications suggested that the system was set up with no clearly identified extra budget for RNs undertaking determinations, and that some district nurses were suffering stress because they felt party to a form of means-testing (Nursing Times, January 2002). On-line publication of one PCT FNC meeting further endorsed the view that 'no allowance [was] being made within the RNCC allocation formula for funding the costs of nurses' time in undertaking the RNCC determinations and continence assessments' (Meeting of Bristol North PCT Board, December 2002).

1.3.3 Funding for NHS FNC

For the first phase of implementation, covering 1st October 2001 to 31st March 2002, an investment of £100m was identified by DoH for this six month period. This included allocations to individual HAs to cover costs for registered nursing care based on the number of self-funding residents (total residents 42,732) located in their care homes, plus the costs of assessing nursing needs, general administration, and included £6m for PCTs in support of continence services and products (DOH, 2001 f, Appendix 2). The

total allocation was based on figures recorded in a DoH Survey in June/July 2001 of 97 Registration and Inspection Units in HAs (DoH, 2001 k) and given as an average of £85 per self-funding resident per week (DoH, 2001 f) Individual funding to the 95 HAs in England for 2001/2002 ranged from £87,000 - £4.4m including continence products (DoH, 2002 e). The total funding allocation for 2002/2003 for NHS funded nursing care was totalled at £220m to cover an estimated 41,000 residents (DoH, 2002 f.) For the period 2003-2004, £584m was given to PCTs, ranging from £94,000 to £5.9m, to cover the estimated 130,264 self funding and LA residents (DoH 2003 e) . These allocations all included the costs of continence products.

PCTs were advised by the Department of Health (DoH 2001 f) that systems would need to be set up to pay care homes for registered nursing care costs from October 1st 2001. In order to implement RNCC payment, PCTs could use the existing social services payment systems with care homes, or utilise an invoicing system until separate contracts could be drawn up.

In association with the introduction of NHS FNC, a model contract was also provided by the Department of Health (DoH, 2001 f, Appendix 1; DoH, 2002 b) that set out clearly the obligations upon NHS bodies and care homes for dealing with the RNCC, including the method of payment of the RNCC for eligible residents, and arrangements for continence promotion aids and specialist equipment. For care homes, the contract specified the requirement to keep either a separate account of an individual resident's RNCC funding, or reduce the resident's invoice by the relevant amount. Subsequently, the Government announced further amendments to the Care Home Regulations 2001 (DoH, 2002 g), that obliged homes to provide a breakdown of their fees, to make clear to self-funding residents, which aspect of their fee is related to registered nursing care and which to residential care, and how these are calculated. It was anticipated by Government that use of a core contract as a basis for local agreements would help to bring greater clarity to the contractual process between the NHS and care homes. The Chair of the National Care Standards Commission was also asked to ensure that any contributions to fees by the NHS or a local authority are recorded separately from other contributions (standard two of the National Minimum Standards for Care Homes, DoH 2002 a), and it has been suggested that it would be possible to cancel a care home's registration if such breakdowns are not made available to residents.

In October 2001, the Government had also launched a new agreement (*Building Capacity and Partnership in Care*. DoH 2001 d) to encourage councils and the independent sector to enter into longer term agreements about placing older people in care homes, or giving them other forms of support. An additional investment of £300m was associated with this agreement, principally to help reduce delayed discharge. It was suggested that agreements drawn up with the private and voluntary home care sectors, health and housing organisations "would help to stabilise the care home sector and create greater confidence in the future of the sector" (DoH 2002 g). Joint commissioning arrangements were encouraged

with NHS and LAs agreeing mechanisms, budget and payment processes and accountability procedures with development of pooled funds towards fully integrated approaches including pooled budgets, joint contracting, single payment systems and single budget managers (DoH 2003 c). This approach would provide closer integration of health and social services to avoid delays in transfer of care arising from disputes over funding responsibilities.

In view of the rapid time scale for implementation of NHS FNC for self-funding residents, it was also agreed by the Department of Health (DoH 2001 f, para 32) that care homes should receive a *block payment* in respect of the amount required for self-funding residents from October 1st 2001. PCTs were advised to carry out RNCC determinations for all self-funding residents by the end of December 2001, and adjustments would then be made to the original payments according to the outcomes of the determinations.

In terms of FNC, the aim of the above measures was stated to be "to ensure that residents and their families receive comprehensive information about what their fees are paying for, and that "the good practice that is already being carried out in some care homes is spread across the whole country" (DoH, 2002 g). However, in a report from the Alzheimer's Society (2002) related specifically to the introduction of FNC, one conclusion was that FNC payments were being retained by care homes rather than the reimbursement being given to residents with dementia via a reduction in fees. Further conclusions were that people with dementia were being inappropriately allocated to the low RNCC band, and were informed that they did not qualify for FNC, despite their condition, because their needs were perceived as personal care.

Initial levels of funding for the three RNCC determination bands were £110, £70 and £35 per week, for high, medium and low bands respectively. In response to the FNC consultation, the Registered Nursing Home Association (RNHA, 2001) pointed out that the difference in staff costs between nursing homes (55% of all costs) and residential homes (35% of all costs), was not considered when establishing the values of RNCC bands applicable to both settings, and that care provided by care assistants, as a part of the provision of nursing care, could not therefore be excluded. Following a members' survey by the RNHA of nurse time for residents with complex needs, it was estimated that the true costs for each RNCC banding level would be higher than those proposed, i.e. High £420, Medium £140, and Low £89 (RNHA, 2001). From April 2003, the banding values have been raised to: High £120, Medium £75 and Low £40 per week (DoH 2002, h)

In Wales, use of a similar variable rate administered through a banding arrangement was questioned from the outset because of concerns that it could generate substantial administrative costs for care providers, with the National Assembly favouring a single standardised rate (National Assembly for Wales, 2001). In

the event a single band system was introduced with an initial allocation of £100 per week per person for the estimated 2,400 self-funding residents requiring nursing care. In Scotland, self-funding residents already in care homes on March 31st 2002 would be subsequently eligible for a payment of £145 per week for personal care, and if in receipt of nursing care, they would receive a further £65 per week. Assessment of personal and/or nursing need was applied for those entering a care home after 31st March 2002 but not for those in a care home before this date (Scottish Executive, 2002).

There remained controversy in England over the concept of not funding personal care. In an opinion poll of 1,000 members of the general public concerning the funding of long term care, commissioned by the King's Fund (Deeming, 2001), the results demonstrated that a majority of people believed that personal care should be free to all who need it and irrespective of the setting where it is delivered. Similarly, in a MOR1 poll of adults (MORI, 2002) 75% of those surveyed thought that the Government should provide free personal care for all older people who need it.

1.3.4 The RNCC determination process

The RNCC determination process requires a NHS registered nurse to consider a resident's need for registered nursing care against a pre-set matrix that also incorporates health related concepts of stability, predictability, risk and complexity, since these might influence nursing care requirements. The available guidance on good practice in the conduct of RNCC determinations was heavily dependent on the assumption that SAP (DoH, 2001 e) for new residents would be implemented from April 2002. In this context, it was recommended that the RNCC be an integral part of assessment and that it draw on 'all assessment information to determine the most appropriate level of registered nursing input' (DoH, 2001 i, p10).

People who need to live in a care home are vulnerable and often have a fragile health status. A level of need, with or without a requirement for registered nursing care, that has been established at one point in time could therefore rapidly become more complex, potentially unstable and unpredictable and place the resident at greater risk. Therefore, it was planned that a review of individual banding decisions would take place 3 months after the initial determination and then on an annual basis, although more frequent reviews could be required for some individuals. Requests for unplanned reviews prior to the annual determination were to be channelled through the nursing home co-ordinator. However, since this individual would also be the budget holder for FNC in the PCT, this might produce a certain conflict of interest. Similarly, if a resident's condition improved the onus would be on the care home manager to request the review, and this again could raise conflict of interest.

Where the resident or relative disagrees with the RNCC determination's outcome, a review process can be requested through appeal via the NHS nursing home co-ordinator to a local Continuing Care Panel, whose remit has been expanded to encompass such circumstances. It was unclear at the outset of the study

whether there would be any backdating of funding for people who were later assessed to need a higher band as a consequence of appeal, or return of funds from those re-assessed at a lower band.

1.3.5 The RNCC tool

The RNCC tool had been assessed for feasibility and reliability, prior to its implementation, in a small evaluation study commissioned by the Department of Health and carried out by two of the authors of this report (Wild & Ford 2001). In this study, RNCC determinations were conducted by independent researchers on 152 residents in 8 nursing homes, based solely on available assessment and care plan documentation in the care home. At the same time, determinations were also undertaken independently by the nursing home RN known to the resident. Comparison of both sets of allocation to bands indicated significant differences in levels of agreement ($\chi^2=32.53$, $df=4$, $p<0.001$). This was not surprising since a poor standard of care plans and assessment documentation was observed in the study homes, especially in terms of the information they provided to enable comprehensive decision-making as to the resident's needs for RN care. It was concluded that a confident and reliable determination of a resident's registered nursing needs may require input from the RN known to the resident, especially if a person-centred rather than a paper-centred determination is to be achieved.

Achieving a person-centred approach, as prescribed in standard 2 of the NSF for Older People (DoH 2001 b), requires that a determination is undertaken with direct involvement of the user, significant others and the nurse best known to the user. Such good practice is dependent upon the RN undertaking the determination having both the time available and holding person-centred values. The evaluative pilot (Wild & Ford 2001) further concluded that a greater emphasis should be placed upon the RNCC tool as a means of guidance towards a '*best fit*' outcome for a resident's needs in terms of band allocation, rather than as a prescriptive measure. This conclusion recognised the importance of professional *judgement* in relation to the achievement of person-centred care, when taking account of the diversity of residents' needs and illness responses which do not always fit the bands' given criteria. The potential for conflict between the registered nurse's RNCC determination outcomes and those perceived by the care home nurses who know the residents suggested that a joint determination approach needed to be adopted in order to resolve these differences, and to pre-empt the need for formal appeals. An initial telephone survey of regional contacts at the proposal stage of this study indicated that in some localities, NHS registered nurses were meeting with care home staff, residents, and relatives as a matter of course, as well as scrutinising documentation.

1.3.6 Conclusions

From the above discussion, it is evident that the implementation of NHS funded nursing care in care homes in England could not be considered in isolation from other changes being introduced at the same time, including the National Service Framework for Older People (DoH, 2001 b), structural changes in primary care given in *Shifting the Balance of Power* (DoH, 2001 a), the Single assessment process (DoH, 2001 e) with inter-disciplinary working across health and social care assessments, Intermediate Care (DoH, 2001 c), and the National Minimum Standards for Care Homes (DoH, 2002 a).

The present study was commissioned by the Department of Health in May 2002 to examine the introduction of NHS FNC in care homes in England, and to explore any associated issues that might need to be addressed by this Department.

At the outset of the study, it was not known how professionals involved in determinations were faring under the new system or how care home managers and staff were reacting to these important changes. Thus, the first stage of the research consisted of a comprehensive set of activities. These included contacting NHS stakeholders, RN users and care home staff to obtain quantitative data on the determinations carried out, opinions about the process and use of the RNCC tool, and exploration of the developing relationship between NHS professionals and care home providers and staff. In addition, information was sought on the new process introduced for the provision of continence aids and specialist equipment to residents. Data were also gathered through national surveys of RNs undertaking determinations; lead staff working in PCTs/ SHAs; and nurses and managers in the independent sector. In later stages, this national overview was supplemented by further national surveys and a more in-depth qualitative study of selected localities examined as an integrated whole. Relatives/ carers of residents who had undergone RNCC determinations were also interviewed in the localities selected.

CHAPTER 2

STUDY DESIGN

2.1 OVERVIEW OF STUDY

Table 2.1 provides an outline of the study, designed to be completed within a 12 month time-frame. The project started in June 2002, one month later than planned while contracts with the Department of Health were being confirmed. The research comprised three stages. Stage 1, from June - November 2002 consisted of interviews with four samples of stakeholders drawn from Regions, SHAs, PCTs and independent care homes. In addition, three national surveys were conducted by postal questionnaire with PCT co-ordinators/ lead nurses, RNs undertaking RNCC determinations, and staff in a stratified sample of independent sector care homes. In stage 2 from December 2002 - March 2003, three further postal surveys seeking a greater depth from that obtained in stage 1 were conducted with a sample of co-ordinators/ lead nurses, RNs and care home staff. Finally in stage 3, individual and group interviews were conducted between April 2003 and June 2003 in two localities with professionals reflecting the surveys' samples. Interviews were also conducted with service users (i.e. with carers / relatives of residents).

Table 2.1: Study Stages and Types of Data Collections

Study Stages	Types of Data Collections and Samples
Stage 1. June - November 02	Interviews: Regional stakeholders Interviews: (Strategic) Health Authority (SHA) stakeholders Interviews: Primary Care Trust (PCT) stakeholders Interviews: Independent care home stakeholders Questionnaire A: Co-ordinators/ lead nurses Questionnaire B: Registered nurses (RNs) involved in RNCC determinations Questionnaire C: Independent homes key staff
Stage 2. December 02-March 03	Questionnaire AB: Co-ordinators/ lead nurses and RNs involved in RNCC determinations Questionnaire CC: Independent care homes key staff
Stage 3. April –June 03	In-depth interviews: Qualitative locality study representative of all of the above samples and including relatives of care home residents.

In order to gather initial qualitative data on the implementation of NHS funded nursing care, addressing different organisational issues at national level, interviews with key stakeholders were conducted as part of the Stage 1 process.

These interviews were semi-structured with schedules sent in advance to those interviewed. Stage 1 and 2 postal surveys were designed to collect predominantly quantitative computer-compatible data that would provide a more complete profile of NHS FNC in practice, building on the Stage 1 interviews in the case of the Stage 1 survey. All questionnaires were scanned into an Access database. In the main, these data permitted the use of descriptive statistics and where appropriate inferential statistics during the analysis. In contrast, in the localities study (Stage 3) the over-arching purpose of the in-depth qualitative interviews was to further explore issues arising from Stages 1 and 2 findings, which could not be addressed by quantitative methods alone but were considered to be of substantial practical importance (Murphy and Dingwall, 2001:166; Gomm, Needham and Bullman, 2000). This combination of qualitative and quantitative methods has a valuable role in data analysis of health services research (Barbour, 1999).

2.2 STAGE 1 STAKEHOLDER INTERVIEWS

2.2.1 Method and materials

Stage 1 interviews were conducted during a period of major change, so great effort was required to identify and track down the interviewees selected, including a sample of 25 regional contacts, in all 28 SHAs and a sample of 30 PCTs. At the time of stage 1 of the study, there was no database of co-ordinators/ lead nurses at the DoH. However Regional contacts for NHS FNC were identified by DoH.

Stakeholder interviews were all preceded by a letter (to Chief Executives at Regional, SHA and PCT level, in the latter two cases asking for a relevant spokesperson to be identified). Initially, there was some confusion between lead nurses in PCTs/ SHAs responsible for managing NHS FNC and lead nurses for older people, i.e. service managers in SHAs and PCTs. In several areas PCTs were still in the process of setting up, whereby appointments had not been established. In some instances email addresses were provided by PCTs or SHAs and this proved to be a more successful means of contact through which follow up e-mails, information and questionnaires could be sent. Despite difficulties with the identification process, once contacted, all stakeholders were helpful both in giving responses to questions and in identifying further contacts and sources of information.

Stakeholders elected for telephone interviews were all sent an introductory letter plus a semi-structured interview content presenting the areas for discussion. These were sent to the eight NHS Executive Regional Office contacts who could still be located at the time of the research; to an identified contact in all 28 SHAs; and to Chief Executives or identified individuals in a random selection of 30 PCTs, representative of all SHA groupings. Telephone contact was made by the researcher within two weeks following these mailings, to arrange a telephone interview time with the member of staff elected to provide the information. In some instances, contact proved difficult due to changing roles/ location or annual leave, but all were finally achieved. The content guide for the interviews is given at Annex 1.

A similar process was used to identify and contact representatives of 10 key care home organisations. These were purposively selected with a regional spread to reflect a range of size and type of homes (single owners or company owned).

2.2.2 Samples and response rates

Interviewees were first contacted in June 2002 and the final interview was completed in November 2002. The samples and response rates for regional, SHA, PCT and care home stakeholders are given in Table 2.2.

Table 2.2: Samples and response rates for stakeholder interviews in stage 1

Study Stage	Types of Data Collection and Sample	Total No contacted	Response Rate N %
Stage 1.	Interviews: Regional stakeholders.	8	7 (87)
	Interviews: Strategic Health Authority stakeholders.	28	17(61)
		30	26 (87)
	Interviews: Primary Care Trust stakeholders.	10	8 (80)
	Interviews: Independent care home stakeholders.		

(i) *Regional interviewees*

The 7 past and present regional stakeholders interviewed included 1 regional nurse executive; 2 SHA directors of nursing; 2 older people's policy leads, and 2 PCT project leaders for FNC.

(ii) *SHA interviewees*

Of the 28 SHAs contacted, those interviewed included 5 policy implementation managers, 6 directors of nursing, 2 programme directors, and 4 older peoples' lead nurses. Of the remaining 11 SHAs, the initial contact considered that the interview should be conducted at PCT level, since there was no identified person with knowledge of RNCC determinations at SHA level.

(iii) PCT Interviewees

Of the 30 stakeholders contacted, 27 who were interviewed included 6 older peoples' lead nurses, 7 directors of nursing, 2 deputy directors of nursing, one nurse consultant for older people, and 2 directors of policy. In 9 PCTs the co-ordinator/ lead nurse was elected as the respondent. One further PCT contact said that the co-ordinator/ lead nurse would send a report in response to the postal questionnaire instead of providing an interview. Two PCTs contacted did not respond.

(iv) Independent care home interviewees

Of the 10 elected care home key stakeholders, one care home group contacted was in the process of downsizing and re-structuring at the time of the request and its new management representative said that there was no time for interview, but indicated that contact at a later time would be acceptable. One further contact refused to be interviewed (no reason given). Of the 8 remaining homes' key staff interviewed, 3 were identified as chief executives, 2 as directors of operations, 1 was a care standards director, and 2 were directors of nursing and quality.

2.3 STAGE 1 POSTAL SURVEYS

2.3.1 Pilots, method and materials

(i) Co-ordinator/ lead nurse and RN stage 1 surveys

Based on the information obtained from stakeholder interviews and advice from the Advisory Board, two slightly different questionnaires were developed for co-ordinators/ lead nurses (questionnaire A - Annex 2) and RNs (questionnaire B – Annex 3) in the new PCTs according to their respective FNC roles. Both questionnaires were piloted prior to distribution with members of the Advisory Board, and with co-ordinators/ lead nurses and community nurses in North Warwickshire. An accompanying letter emphasised the importance of the research (Annex 4). The questionnaires were designed for rapid completion and for data entry using a scanner, with the exception of text comments (written in response to open questions) and information requested on separate pages. To maximise the response rate, the covering letter included the RCN logo and signatures of the lead researcher and a senior manager at the RCN emphasising the importance of the study. The questionnaires took account of the fact that in some localities there would be two separate PCT appointments, i.e. a nursing home co-ordinator (the budget manager) and a lead nurse, whereas in others one person would cover both roles. Thus, although a questionnaire was addressed to both the co-ordinator and the lead nurse in each PCT, where there were two appointments it was suggested that one person be nominated as key respondent for the survey. The questionnaires were distributed in the first two weeks of September 2002.

Because there was no national list of co-ordinators/ lead nurses available via the DoH or other bodies, questionnaires were addressed to the lead nurse for older people in all PCTs, for forwarding to the appropriate person(s). This inevitably led to a considerable (unanticipated) delay due to the need for this cascade contact mechanism, especially as the lead nurse for older people was not necessarily the person responsible for RNCC, or had not as yet been appointed. The mailing for forwarding to the co-ordinator/ lead nurse in a PCT included one copy of the co-ordinator/ lead nurse questionnaire plus five copies of the RN questionnaire. Co-ordinators/ lead nurses were asked to forward a questionnaire to each RN who had experience of undertaking determinations in their PCT. It had been anticipated that RNs could only be identified via their co-ordinator/ lead nurse, so this cascade contact mechanism was as originally planned.

The importance of the survey was emphasised by separate communication from the Royal College of Nursing (RCN) via an email newsletter to community nurses in the membership. Non-responders to the co-ordinator/ lead nurse questionnaire were sent a follow-up mailing in the week beginning 7th October 2002. The PCTs which had not returned a co-ordinator/ lead nurse questionnaire by this date were sent one further copy of their original co-ordinator/ lead nurse questionnaire, plus one copy of the RN questionnaire, to be photocopied as required. At this stage, it was possible to directly mail almost half (43%) of the questionnaires to named co-ordinator/ lead nurse's place of work, since by this time, some location information was available on a DoH database.

Contact details of the respondents to each questionnaire (A and B) were requested, with a view to a further request for voluntary participation in stages 2 and 3 of the study.

Co-ordinators/ lead nurses were asked to return their questionnaire using a FREEPOST envelope provided. RN respondents were invited to either return their questionnaire direct to the research team, or via the co-ordinator/ lead nurse if preferred.

Co-ordinators/ lead nurses and RNs were asked to provide information on the following key areas (see Annex 2 & 3 respectively):

- The number of RNCC banding determinations undertaken in care homes in their PCT area during the period 1st October 2001 - 31st March 2002. This included: overall statistics on banding decisions made; basic details of residents in different bands, including status (existing resident or new admission); and descriptive details of care homes.
- Number of RNs employed and level of expertise
- Information on numbers of residents requiring funding for continence aids and specialist equipment in the PCT during this period.

- The number of determinations resulting in an appeal during the period including; the original RNCC banding decisions; who initiated the appeals; the resolution mechanism for appeals; type of staff involved in the decision-making process; appeal decisions (with outcomes, if available). None of the residents were identifiable to the researchers.
- Resources associated with managing the PCTs determinations of nursing care and the appeals process (co-ordinators/ lead nurses only).
- Available figures on local start up costs, including staff training (co-ordinators/ lead nurses only).
- Estimates of central (i.e. PCT/ SHA) manpower hours and the number and level of staff involved in the management and monitoring of determinations undertaken (co-ordinators/ lead nurses only).
- Overall registered nursing hours devoted to RNCC determinations (co-ordinators/ lead nurses only)
- A brief assessment of the developing relationship between PCT staff and care homes.

(ii) Independent care home stage 1 survey

A separate questionnaire (Annex 5) was developed for care home managers/ key nurses (questionnaire C) and piloted with a member of the Advisory Board representing BUPA. Its content was linked to that of the co-ordinator/ lead nurse and RN questionnaires so that complementary information would be obtained. Once again, there was no comprehensive database available from the DoH of care home in England, including contact details and information on size, type of home etc. Postal address information and named managers of independent homes was eventually provided via the National Care Standards Commission in September 2002 and the questionnaire was distributed during the last two weeks of September 2002, following the distribution of questionnaires A and B.

An email RCN newsletter to community nurses in the membership emphasised the importance of the survey, but it is not clear how many RNs in care homes will have received this newsletter. A follow-up mailing was carried out in February 2003, following discussion of the poor initial response rate with the Advisory Board. This included accompanying support letters from BUPA and the Independent Care Homes Association (IHA) (Annex 6) on the advice of the Advisory Board. The questionnaire was also split into two parts at this stage, one for managers and one for senior nursing staff, on the recommendation of the Advisory Board.

Questionnaire C, addressed to care home managers, requested basic descriptive data on the care home, e.g. number and age ranges of residents, type of nursing care provided (physical and/or mental health care), and number of residents. The manager was asked to provide information relating to the home including basic demographic data on residents. Information was also collected on determinations

carried out during the period 1st October 2001 - 31st March 2002, as well as for new residents between 1st April and 30th June 2002; care home resources devoted to determinations; time spent on determination. Senior RNs were also asked to provide information on the RNCC determinations that had been conducted for existing self funding residents in the home during the period 1st October 2001 - 31st March 2002, as well as for new residents between 1st April and 30th June 2002.

The manager's and senior nurse's levels of agreement with the RNCC determination's banding outcome (strong agreement→strong disagreement) together with any relationship problems identified and resolution process. Data were also gathered from the managers concerning the number of appeals against RNCC decisions in phase one (if any), together with an indication of whether care home staff were involved in the appeals process.

In addition, the number of self-funding residents in the care home requiring continence promotion aids/other equipment were recorded, and if NHS assessment for these had taken place, what type of aids/ equipment were required. General views on the management of the determination process, and a brief assessment of the developing relationship with the NHS were also requested. Contact details of the respondents to questionnaire C were requested, with a view to a further request for voluntary participation in stages 2 and 3 of the study.

2.3.2 Samples and response rates

(i) *Co-ordinator/ lead nurse and RN stage 1 survey responses*

The survey samples and response rates for co-ordinators/ lead nurses/ RNs are given in Table 2.3. The number of mailed PCTs is known, but the number of co-ordinators/ lead nurses who might be expected to respond is not known, since some PCTs had appointed a combined co-ordinator/lead nurse, whereas other PCTs had appointed two persons to cover the two roles. Thus the percentage response rate is a (minimum) estimate based on the number of PCTs. The number of RNs employed to undertake determinations is not known.

Table 2.3: Samples and response rates for stage 1 co-ordinator/ lead nurse and RN surveys

Study Stage	Types of Data Collections and Samples	Total N	Response Rate N %
Stage 1.	Questionnaire A: Co-ordinators/ lead nurses Questionnaire B: RNs involved in determinations	304 (est) n/a	89 (29 %) 102 (n/a)

Co-ordinator/ lead nurse survey: Following reminders, a total of 89 co-ordinator/ lead nurse questionnaires were received by the end of December 2002, giving a minimum 29% response rate from the 304 PCTs to which questionnaires were distributed. Of the 89 respondents, 35 (40%) held a

combined co-ordinator/ lead nurse role, 15 (17%) held the role of *co-ordinator only*, and 32 (36%) held the role of *lead nurse only*. Seven people (8%) did not indicate a job role.

The geographical spread of respondents is given in Table 2.4, by geographical area rather than by PCT, since some co-ordinators/ lead nurses are known from survey responses to cover up to 6 PCTs. The Table demonstrates that responses were received from all geographical areas with the exception of Thames Valley. The highest percentage response rates were from Essex (62%) and North & East Yorkshire, & North Lincolnshire (60%). Whereas the lowest response (apart from Thames Valley) was from South Yorkshire (11%).

RN Survey: Five copies of the RN questionnaire were sent to all 304 PCTs for cascade distribution via the co-ordinator/ lead nurse to all RNs who were conducting determinations. By the closing date, only 55 RN questionnaires had been returned. However, several respondents either telephoned or emailed during this period to say that their questionnaire had only just been received because of the circuitous process of double cascade mailing and, in some cases, absence due to summer holidays. The closing date was therefore extended to permit these and other individuals time to return the questionnaire. By the end of December 2002, a total of 102 RN questionnaires had been received.

Table 2.4: Geographical distribution of co-ordinator/ lead nurses survey responses by PCT

Geographical Area	Number of PCTs	Response (%)
London	7/33	21%
Northumberland, Tyne and Wear	2/6	33%
County Durham & Tees Valley	5/10	50%
North & East Yorkshire, & North Lincolnshire	6/10	60%
West Yorkshire	7/15	47%
South Yorkshire	1/9	11%
Cumbria and Lancashire	6/13	46%
Greater Manchester	5/14	36%
Cheshire and Merseyside	3/15	20%
Trent	4/19	21%
Leicestershire, Northamptonshire & Rutland	3/9	33%
Shropshire & Staffordshire	3/10	30%
Birmingham and the Black Country	2/12	17%
Coventry, Warwickshire, Herefordshire & Worcestershire (West Midlands)	3/8	38%
Thames Valley	0/15	0%
Norfolk, Suffolk & Cambridgeshire	2/17	12%
Bedfordshire & Hertfordshire	2/11	18%
Essex	8/13	62%
Hampshire & Isle of Wight	4/10	40%
Kent & Medway	2/9	22%
Surrey & Sussex	4/15	27%
Avon, Gloucestershire & Wiltshire	5/12	42%
South West Peninsula	3/11	27%
Somerset and Dorset	2/9	22%

(ii) Care home stage 1 survey responses

A sampling frame of independent sector care homes was developed for the stage 1 survey, as shown in Table 2.5. This included large and small homes; homes owned by nursing care organisations (e.g. BUPA); privately owned homes; and homes providing care for residents with mental illness and/or physical conditions. Access to information on these homes was facilitated through contact with the National Care Standards Commission (NCSC) and senior care home organisations' managers in the independent sector. A total purposive sample of 511 independent care homes was identified in this manner, to allow coverage of most SHAs / PCTs and to provide a large enough sample in each category of care home for analysis.

Table 2.5: Sampling frame for survey of independent care homes

Large chains => 39 homes	Number of Homes in Chain	Number of homes in sample
Ashbourne Homes Ltd	60	15
BUPA	162	35
Four Seasons	84	19
Leonard Cheshire Homes	39	10
Southern Cross	109	23
Westminster Healthcare	57	8
<i>Total homes = 511 Sample 1 in 4 =102 homes.</i>		
Medium chains =>18 and <39 homes	Number of Homes in Chain	Number of Homes in Sample
ANS Homes Ltd	27	12
Barchester	18	6
Bettercare UK Ltd	24	12
Community Integrated Care	26	5
Coverage Care (Gloucs)	19	10
Highfield	32	14
Parkcare	18	7
Union Healthcare	19	9
<i>Total homes =183 Sample 1 in 2 =101 homes.</i>		
Small chains =>10 and <18 homes	Number of Homes in Chain	Number of Homes in Sample
Anchor	16	8
Care Community Partnership	15	8
Colton Care	11	4
Eastwood	15	6
Goldsborough	16	7
Harden	17	1
Helen McCardle	14	5
High Clear	14	6
Laudcare	10	3
Lifestyle	13	4
Mimosa Healthcare	10	5
MEND	10	5
Milbury	11	5
Prime Life	12	6
Ridgemont	18	8
Royal Masonic	12	6
Brandon Trust	13	6
<i>Total homes = 227 Sample 1 in 2 homes = 108.</i>		

Very Small Chains and Individual Owners =<10 homes	Number of Homes in Chain	Number of Homes in Sample
Elizabeth Finn	5	5
National Schizophrenia	5	5
Care UK Mental Health Partnerships	4	4
London Residential Healthcare	5	5
Mental Health Coverage	7	7
Sue Ryder	9	9
Individual owners homes	3264	65
<i>Total homes = 3299. Sample 35 plus *1 in 50 =65 =100.</i>		

The 411 homes in the sample represented large, medium, small and very small chains (328 homes) plus a sample of one in 50 individually owned homes (65 homes) on a geographically representative basis.

Seventy five questionnaires were returned by March 2003 from a total of 411 care homes' managers, giving an 18% response rate. From Table 2.6, it is evident that managers of individually owned homes were those most likely to respond (38%), with care homes' managers who are part of a large chain (29%) or very small chains (26%) the next most likely to respond. Medium and small chain homes' managers were least likely to respond.

Table 2.6: Response rates for stage 1 survey of independent care homes

Type of care home	Number of homes in total	Number of homes in sample	Respondents n (%)
Large chains => 39 homes	511	102	30 (29%)
Medium chains =>18 and <39 homes	183	101	6 (6%)
Small chains =>10 and <18 homes	227	108	5 (5%)
Very small chains =<10 homes & individual owners	3,299	100	34 (34%)
Last category broken down:			
<i>Very small chains =<10 homes</i>	<i>35</i>	<i>35</i>	<i>9 (26%)</i>
<i>Individual owners</i>	<i>3,264</i>	<i>65</i>	<i>25 (38%)</i>

Furthermore, as shown in Table 2.7, one half of the 75 care homes' managers who replied, described the care focus of their home as being for residents with physical impairment, and approximately one quarter for residents with physical and mental impairment. Of the remaining quarter only 8% of the respondents described the care focus as mental impairment alone.

Table 2.7: Type of Independent Care Home and Care Focus

Predominant Care Focus	Care homes	
	n=75	%
Physically impaired	38	51%
Mentally impaired	6	8%
Physically & mentally impaired	18	24%
Learning difficulty	1	1%
Unknown	12	16%
Total	75	100%

2.4 STAGE 2 POSTAL SURVEYS

This stage of the study used further surveys to enable a more detailed picture to be built up about the process of determination. Stage 2 would also inform the selection of localities to be studied in greater depth in stage 3.

2.4.1 Pilots, method and materials

(i) Co-ordinator/ lead nurse and RN stage 2 surveys

Separate stage 2 questionnaires were not prepared for co-ordinators/ lead nurses and RNs since analysis of stage 1 responses had revealed that almost half (47%) of the co-ordinators/ lead nurses were also undertaking determinations (i.e. the RN role). It was therefore deemed appropriate to send the same questionnaire to both cohorts, as an adequate means of distinguishing roles was included in the questionnaire. The content of the questionnaire was discussed with the Advisory Board because it had largely been left 'blank' in the protocol with the aim of focusing on issues emerging from stage 1. The Board advised that the questionnaire should capture information relating to April 2002 onwards. Furthermore, although it had been planned that RNs would be asked to provide comprehensive details on the 10 most recent determinations, it was suggested by the Advisory Board, that by excluding this additional task, the response rate could be improved.

The content of questionnaire AB (Annex 7) was developed based on this advice and from the analysis of stage 1 data. Additional information collected included: roles and responsibilities; main duties; budget holding; experiences of RNNCC determinations; appeals processes; informal reviews; identification of new residents; and opinions on impact of RNCC. The questionnaire was piloted in a local Warwickshire PCT before distribution.

(ii) Independent care home stage 2 survey

The stage 2 questionnaire CC for care homes (Annex 8) was developed from the data analysis of the stage 1 related data and provided the opportunity to obtain more comprehensive information on specific aspects such as the developing relationship between the NHS with care home staff. In addition, it included more detailed information on:

- number and type of residents
- participation of care home staff in the determination process
- timing of determinations
- reasons for and process of appeals
- information on determination provided to staff and residents/relatives
- quality assurance processes
- processes of continence and specialist equipment assessment
- funding processes and fees
- opinions on the impact of the introduction of RNCC determination.

2.4.2 Samples and response rates

(i) Co-ordinator/ lead nurse and RN survey responses

It was planned that a sample of approximately 80 PCTs would be surveyed using a postal questionnaire in stage 2. The option of reducing the number of PCTs to enable the questionnaire to be administered by telephone (mailed in advance) and thus achieve a higher response rate was discussed with the Advisory Board. It was agreed that the second stage survey should maintain the aim of covering ca 80 PCTs, but that every effort should be made to ensure a high response rate to the postal questionnaires. In order to do this it was agreed that PCTs should only be included if full contact details of the co-ordinator/ lead nurse were available using either the Department of Health's updated database, or information supplied on returned questionnaires, or information obtained from telephone stakeholder interviews.

A purposive sample of PCTs was chosen within this group based on:

- banding patterns;
- number of RNs employed and their level of experience/ inexperience
- level of appeals and informal reviews.

Thus, as shown in Table 2.9, questionnaires were finally sent to all the 89 co-ordinators/ lead nurses (and to 73 RNs). Forty (45%) of the co-ordinators/ lead nurses returned the stage 2 questionnaire but only 7 (10%) of the RNs responded. Thus, the combined sample gave an overall response rate of 29%.

Follow-up of non-responders was not possible for the stage 2 survey because of cumulative time slippage due to the earlier difficulties in identifying mailing databases for stage 1 and the follow-up mailings required to maximise response rates to the stage 1 surveys.

Table 2.9: Samples and response rates for stage 2 co-ordinator/ lead nurse and RN surveys

Study Stage	Types of Data Collections and Samples	Total N	Response Rate N %
Stage 2.	Questionnaire AB: Co-ordinators/ lead nurses and RNs	162*	47 (29)*

*Combined sample comprising co-ordinators/ lead nurses and RNs

(ii) Care home survey responses

Questionnaires were sent to all the 75 independent care homes who had responded in stage 1 but only 12 had been returned (16%) by the end of April 2003. In order to improve the response rate, non-responders were sent another questionnaire and a further 12 homes from the total sample, who had not responded in stage 1, were contacted by telephone to ask if they were willing to complete the questionnaire for stage 2. These 12 homes were sent the stage 2 questionnaire and subsequently they were completed. The final response rate by June 2003 was 48%, as shown in Table 2.10.

Table 2.10: Response rates for stage 2 survey of independent care homes

Study Stage	Types of Data Collections and Samples	Total sample of all homes	Total N (75+12)	Response Rate N %
Stage 2.	Questionnaire CC: Independent care homes' key staff	376	87	42 (48)

Table 2.11 presents the response rate according to the size of care home. As with stage 1, the lowest response rates were from medium and small homes, with the highest response rates from very small chains/ homes owned by individual owners or homes belonging to the large chains.

Table 2.11: Response rates for stage 2 survey of independent care homes

Type of care home	Number of homes in total sample	Number of homes in sample responding to stage 1	Respondents to stage 2 N* (%)
Large chains => 39 homes	102	30 (29%)	16 (16%)
Medium chains =>18 and <39 homes	101	6 (6%)	8 (8%)
Small chains =>10 and <18 homes	108	5 (5%)	4 (4%)
Very small chains =<10 homes & individual owners	65	34 (52%)	14 (22%)

* Responders to stage 1 plus 12 previous non-responders

2.5 STAGE 3 LOCALITIES STUDY

2.5.1 Selection of localities

Two localities were to be selected as study sites based on analyses of stages 1 and 2 survey responses. One was to be chosen on the basis of evidence of a high level of satisfaction and 'good practice'. In contrast, a further locality was to be selected on the basis of findings indicative of challenges within the delivery system.

A number of locations were initially identified by the study team, based on pre-defined criteria. These included reported acceptability of the RNCC tool; number of appeals on banding decisions (if there were any reported); satisfaction with training; identification of a budget for the introduction of NHS FNC; and whether the survey respondents reported satisfaction or otherwise with the determination process in practice. The final two localities were selected based on the above criteria and agreed with the DoH.

The descriptions of the 2 localities are as follows:

Location 1: North England, large urban town. The PCT serves a population mix of affluent wards while also containing areas with the usual problems relating to inner-city needs and social deprivation (population circa 140,000). The number of elderly people aged 65 and over in location 1 is 28,928 (ONS Census 2001). Total number of determinations were 148 (October 2001 – March 2002) and 138 (April – June 2002). This PCT employs three RNs, median number of determinations per nurse were 49 and 46 respectively for the two time periods. There had been no appeals.

Location 2: South England, large urban city. The PCT serves a similar mix of mix of population to location 1 (population circa 190,000). The number of elderly people aged 65 and over in location 2 is 27,535 (ONS Census 2001). The total number of determinations were 148 (October 2001 – March 2002) and 72 ((April – June 2002). This PCT employs one RN. There had been no appeals.

2.5.2 Method and materials

Stage 3 of the study permitted a more systemic and process-driven investigation of the general views of professionals than those captured through stage 1 and 2 postal surveys, and allowed more detailed exploration in a locality than the stage 1 stakeholder interviews, whilst also investigating issues (positive outcomes or challenges) which were specific to the localities under study. Furthermore, as user perspectives were not gathered in either the stage 1 or stage 2 data collections, these were addressed in Stage 3. This part of the research involved the use of multi-methods, including telephone and face-to-face interviews (both individual and group for the latter). The use of interviews at this stage also had the added bonus of recording participants' recommendations to improve the system.

A purposive sample (Robson, 1993) of professionals and users/carers was selected from the two localities chosen for the in-depth study. A total of 23 participants agreed to take part in semi-structured interviews (see 5.2.2). All those who took part in this stage of the study (*Stage 3*) were given a copy of the questions used for these interviews and a summary of the study, the basis of informed consent (Keats, 2000). The majority of these interviews ($n = 16/23$) were recorded on audio-tape and the transcriptions of these interviews analysed. The remainder ($n = 6/23$) of these interviews were analysed for interview content from the researcher's field notes recorded at the time.

(i) Professional

All participants were observed in as natural a way as possible so that the researcher became an integral part of the research process. The aim for *Stage 3* was for the researchers to attempt to 'make sense' of the social meanings professionals bring to their work; in this case issues relating to the *process* of the determination of funded nursing care in care homes. The practicalities lying behind the application of the RNCC determination tool and its national implementation were also explored. The interview questions (Annex 9) were used as a prompt during these interviews since they covered the topics explored in the *Stage 1* and *Stage 2* surveys, thus contributing to triangulation of the data. The following question areas outline the interview content:

- Co-ordinator/lead nurse roles (NHS)
- Staffing for RNCC including recruitment and retention (NHS)
- Implementation of the Single Assessment Process (SAP) (NHS)
- Funding for RNCC and systems for monitoring payments. (NHS & independent homes)
- The way forward for future of RNCC (NHS & independent homes)
- Positive outcomes and challenges of RNCC (NHS & independent homes)

Data from the majority of the in-depth interviews ($n = 17/23$) were analysed using IPA (Smith, Jarman and Osborne, 1999). Themes from the data were organised into emergent categories and examined for patterns, connections and contradictions before being incorporated into a consolidated list (see 5.5.2 and **Table 5.3**). Documentation relating to determination of funded nursing care provided by participants in the localities was also studied by the researchers. Field notes and notes made by the researchers during and after the interviews were also examined and analysed for content (Gillham, 2000; Denzin & Lincoln, 1998; Henwood, 1996; Robson, 1993). This then provided a quality check as a part of the wider research audit process.

(ii) Users / carers

Views of the service users were also obtained by interviewing a sample of care home residents' relatives and families ($n = 6$). These were shorter interviews and, with one exception (interviewee seven, location one), were conducted over the telephone. Both locations had initially expressed

willingness for members of the research team to conduct interviews with residents and / or carers. However, in reality, some resistance to interviewing care home residents in the second location was encountered by the researchers. This was probably due to some degree of uncertainty concerning the overall purpose of the research since, professionals in this location were later happy to agree to a member of the research team conducting some briefer interviews over the telephone with members of residents' families (n = 5). The following question areas outline the interview content:

- Levels of: inclusion (including relative) in RNCC process, quality of information received, and comprehension.
- Perceived fairness of RNCC outcomes from user residents who have recently undergone determinations.
- Whether residents understand the reason for this determination .
- Receipt and opinion of continence and other specialist equipment.
- Experience of dissatisfaction with determination leading to appeal or *resolution before* appeal.
- Do user residents perceive funding as being in addition to existing resources (RN time) or part of existing resources?
- Do user residents perceive funding as a means of raising the standards of care in nursing homes?
- What examples could user residents give that indicates positive change in their care since their receipt of funding?
- How was any funding managed by resident users (if relevant)?
- Opinion of conduct of assessments (and assessor) for continence promotion aids and other specialist equipment

Data from the interviewer's notes from these interviews were analysed for content with these results being reported in Chapter 4 (see 4.4.1: Users' perceptions of determination of NHS funded nursing care

2.53 Interviewees

In total, 23 people provided information on their views of the determination of NHS FNC across the two localities in Stage 3. These interviews included professional (n = 17) and user (n = 6) perspectives. Seventeen people were interviewed face to face (13 women and four men: 16 professionals and one service user). The majority of these interviews (n = 16/23) were recorded on audio-tape. One other in-depth interview was conducted with a woman professional but it proved impossible to audio-tape this interview, due to a high level of background noise from building alterations in the vicinity. In this instance, researchers' field notes were therefore analysed for thematic content instead

A further six people were later interviewed by telephone (one professional and five close relatives of service users) shown in Table 2.12. The majority of these interviews were on a one-to-one basis but, in addition, views were obtained by the researcher sitting in on team meetings. Thus, some material was provided by participants who appear in the data transcripts for more than one interview. The data from these interviews were analysed qualitatively and examined for thematic content.

Table 2.12: Summary of interview participants for two localities (N = 23)

Participants (N = 23)	Gender	Professional / user role	No. audio-taped interviews	No. telephone interviews
17 professionals	13 women 4 men	2 PCT lead nurse co-ordinators 2 PCT lead nurse assessors 2 discharge nurses 1 PCT administrator 1 PCT service manager nurse director 2 care home managers 1 care home owner/manager 5 members of care home nursing staff 1 PCT finance officer	16	1
6 relatives of care home residents	3 women 3 men	1 son of resident 2 husbands of residents 3 daughters of residents	1	5

Themes for the interview schedule were developed using respondents' written responses from the questionnaire survey (*Stage One*). Transcripts of these in-depth interviews were analysed using IPA. Field notes for the briefer telephone interviews were analysed for content using Content Analysis.

Of these 23 interviews, 11 interviews in Location One and five in Location Two were recorded on audiotape. Of those audio-taped, one was a PCT co-ordinator/ lead nurse; two were PCT nurse 'assessors' with the role of carrying out the determinations (one with a role for mental health); two were discharge nurses, one a PCT Administrator; one was a PCT service manager, Director of Nursing (previously held the role of lead nurse for implementation); two were care home managers (one was a manager for an EMI home)²; five were care home nursing staff (matron, assistant matron, sister, staff nurse and registered nurse), and one was a care home resident's partner. Two people were audiotape interviewed on two occasions i.e. during team meetings in addition to individual interview.

Of the other interviews (all in location 2), one care home owner / manager interview (interviewee 17) was recorded using field notes (the preferred method chosen by interviewee as there was background noise). The remaining six interviews, for five relatives of care home residents, were conducted by

² Care homes for the 'Elderly Mentally Infirm' were identified as 'EMI homes'

telephone as the interviewees were unavailable at time of location visit. In all cases, consent to interview was obtained prior to interview and, as in audio taped interviews, there was adherence to the interview content guide.

Although at the outset, both locations' care home staff expressed a willingness for members of the research team to conduct interviews with residents and relatives, in the visits to the locations, a resistance to facilitating these, in particular in location 2, was encountered. Follow-up requests for these interviews were made at a later stage, and eventually, after notices about the study requesting resident/ carer volunteers for interview had been displayed in the homes, care home staff did agreed to facilitate access to some relatives of residents in location 2, but only via telephone interview.

2.6 ETHICAL CONSIDERATIONS AND DATA PROTECTION

The principles of full written and verbal study explanation, consent, right to withdraw, doing no harm, and confidentiality and anonymity was adhered to throughout the study (Merril *et al* 1995). Ethical approval was sought from MREC for stages 1 and 2 of the study to cover information derived from documentary records in terms of RNCC determinations and appeals. Furthermore, when the analysis of Stages 1 and 2 data identified the localities for Stage 3 of the study, further approval was sought from MREC and local ethics committees were also notified in the two localities. The responsibilities of the researchers within the project's ethical frame-work formed a part of the initial project orientation (McKenzie *et al* 1995). Due care was taken in the selection process of residents' to ensure that persons who were considered to be too ill to participate were not included.

All participants in stage 3 gave fully informed consent and were offered the opportunity to comment on a copy of their interview transcript if they so wished after the interview as part of the participant validation process (Henwood and Pidgeon, 1992). All data was safely stored under the provisions of the Data Protection Act (1998).

2.7 MODIFICATONS TO ORIGINAL PROPOSAL AND THEIR RATIONALES

Table 2.14 outlines NHS policies in relation to the stages of the study. The Autumn of 2001 set in motion significant change in the structures and processes of health and social care in England. In effect, by the time of the commencement of the study's stage 1 postal surveys (A, B and C), many health professional managers were engaged in organisational changes including alterations to their roles and responsibilities. This climate of change is believed to have exerted some adverse influence upon the conduct of the different stages of the study and response rates from both those in the NHS and independent sector care homes, for the following reasons:

(i) Stage 1 interviews

It was expected that this stage of the research would be supported by databases held at the DoH. However, in the event, the process of identifying key FNC stakeholders for stage 1 interviews proved to be extremely slow and difficult because the DoH databases either were not in place, or were incomplete at that time, and because people had either moved post (regional contacts) or individuals were not in post at that time (SHA and PCT stakeholders). These issues created an overlap of stage 1 interviews with the mailing of stage 1 questionnaires to co-ordinators/ lead nurses and RNs. Where the stakeholder identified by PCT senior management was the co-ordinator/ lead nurse, the option was offered to respond by completion of postal questionnaire (A).

(ii) Stage 1 surveys

The major difficulties experienced in identifying co-ordinators/ lead nurses in PCTs due to the absence of a complete database, resulted in the adoption of a two step cascade method of mailing questionnaires for the co-ordinator/ lead nurse and RN surveys in stage 1. The first mailing was undertaken in the week beginning 2nd September 2002. However, since addresses and names were not available in most instances for the co-ordinators/ lead nurses, this mailing was addressed to the 302 PCT head offices in existence at that time (now 304 PCTs). This more complex system of questionnaire distribution to co-ordinators/ lead nurses and thence to RNs, meant that the timing of the questionnaires being forwarded to RNs in particular, began to coincide with the period of summer vacation in the NHS. The low initial response rates thus required unplanned, additional mailings to non-responders to boost response rates. Inevitably, this had some 'knock on' effect in terms of keeping to the intended time-frame for both the processes of analysis of data received in stage 1, and the start of stage 2 activities.

Table 2.14: NHS Key Policies in Relation to the Study's Time-frame

NHS policy issued	Study Stage and Data Collection
<p>2001</p> <p>NHS Plan; Dept. of Health Crown Copyright July 2000. Care Standards Act.2000. Shifting the Balance of Power ; Dept of Health Feb.2001 National Service Framework for Older People, DoH March 2001 Intermediate Care Guidance. DoH 2001 Emerging Framework for Care Trusts; DoH, March 2001 A Guide to Integrating Community Equipment. DoH March 2001 Guidance on Free Nursing Care in Care Homes, DoH, Sept. 2001. Single Assessment Process. Consultation Paper DoH,. Oct. 2001 Building Capacity and Partnership in Care.... DoH, Oct.2001 Continuing Care Guidance, DoH, 2001</p>	<p>Bid preparation</p>
<p>2002</p> <p>National Care Standards Commission DoH, April 2002 National Minimum Standard. DoH, April 2002</p> <p>Guidance on Single Assessment Process, DoH: Sept 2002 Transfer of Funds from PSS SSA to the NHS. DoH, Sept.2002 Guidance on NHS Funded Nursing Care. DoH, October 2002 Building Capacity & Partnerships in Care. DoH October 2002</p> <p>National census of numbers of residents in PCTs receiving nursing care in care homes, DoH December 2002/ January 2003</p>	<p>Start of study</p> <p>Stage 1 June-October 02 Interviews: Regional stakeholders</p> <p>Stage 1 June-October 02 Interviews: (Strategic) Health Authority (SHA) stakeholders</p> <p>Stage 1 June-October 02 Interviews: Primary Care Trust (PCT) stakeholders</p> <p>Stage 1 June-October 02 Interviews: Independent care home stakeholders</p> <p>Stage 1 June-October 02 Questionnaire A: Co-ordinator/ lead nurse</p> <p>Stage 1 June-October 02 Questionnaire B: Registered nurse (RN) involved in RNCC determinations</p> <p>Stage 2 November 02-March 03 Questionnaire AA: Co-ordinator/ lead nurse for Older People</p>
<p>2003</p> <p>Care Home Amendment ;Environmental Standards DoH, Feb.</p> <p>Continuing Care; DoH 2003</p>	<p>Stage 2 November 02-March 03 Questionnaire C: Independent homes</p> <p>Stage 2 November 02-March 03 Questionnaire CC: Independent homes</p> <p>Stage 3 April –June 03 Qualitative locality interviews End of study.</p>

(iii) Stage 2 surveys

The slippage resulting from stage 1 delayed the stage 2 survey of co-ordinators/ lead nurses and RNs (questionnaire AB) and the care homes key staff survey (questionnaire CC). This limited the time available to complete full analyses prior to the commencement of stage 3. The research team was informed towards the end of stage 1 that the DoH would be conducting a census of PCTs during December 2002/ January 2003 to identify the number of residents (both self funding and local authority supported) receiving nursing care in care homes. This was to ensure that the correct amount of funding was made available to PCTs for 2003/04. It is possible that this parallel survey could have had an impact on responses to the stage 2 surveys.

(iv) Stage 3 localities study

Finally, the intention to interview residents and their close relatives in the localities did not prove feasible during site visits, with the exception of one interview in location one. In addition to the short time scale of the locality studies (3 days in total), this lack of access to residents/ carers was mainly due to the reluctance of care home managers to identify volunteers for interview in their own homes. After notices requesting volunteers for interview had been displayed in homes in location two, and follow-up telephone calls made by the researcher, five relatives were identified as willing to participate in telephone interviews but interviews with residents were unforthcoming.

CHAPTER 3

FINDINGS FROM STAGES 1 & 2

3.1 INTRODUCTION

The initial interviews with stakeholders and postal surveys of co-ordinators/ lead nurses, RNs and care home staff in stage 1 established a baseline data set of basic information which was then expanded in follow up surveys in stage 2. These addressed, in more depth, the key issues identified as important to professionals and in line with the main aspects of inquiry for the study, adapted from the guidance provided by the Department of Health (see Table 3.1 below).

Table 3.1: Aspects of Inquiry for the Study

A: Implementation of NHS funded nursing care <ul style="list-style-type: none">• management;• budgets;• training.
B: RNCC Activity <ul style="list-style-type: none">• numbers of RNCC determinations undertaken;• NHS human resources;• time required (NHS and care homes).
C: Determination Process: <ul style="list-style-type: none">• acceptability of RNCC tool by NHS staff and care home staff;• who is involved in determinations;• sources of information used;• quality assurance;• need for modification of the RNCC tool based on national use in the field.
D: Determination Outcomes: <ul style="list-style-type: none">• consistency of decisions made across range of bands within PCTs/ SHAs;• numbers of appeals against RNCC banding decisions: reasons, process and outcomes;• informal reviews.
E: Relationship between NHS and nursing homes <ul style="list-style-type: none">• NHS budget managers and independent sector senior personnel• NHS staff and care home staff• Identification and resolution of problems between NHS and care home staff
F: Continence aids and specialist equipment <ul style="list-style-type: none">• number of residents requiring funding for continence aids and specialist equipment• continence aids and specialist equipment in relation to bandings

Findings from stages 1 and 2 were integrated and grouped under a number of headings relevant to these aspects. In the following analyses, where data are presented the source of any information is denoted by reference to (a) the stage of the study and (b) the data source (e.g. stakeholder interviews, questionnaires A, B, C, AB and CC). This is also related to policy development and the timeline of the study as shown in Table 3.2.

Table 3.2: Timelines of study in relation to policy changes and FNC implementation

NHS policy issued	NHS Funded Nursing Care Implementation Timescale	
2001: <i>NSF Older People</i> 2001 <i>Shifting the balance of</i> <i>Power</i> 2001 October 2001 Single Assessment Process (SAP) 2002: April 2002 National Minimum Standards	2001: <i>Summer 2001:</i> NHS Executive Regional Office contacts named <i>July 2001:</i> DoH survey nursing home <i>August 2001:</i> Allocation of funding to HAs <i>August 2001:</i> RNCC tool developed & evaluated 2001/02: RNCC determinations completed for self-funding residents : <i>31st Dec. 2001:</i> for all existing (Oct 2001) self-funding residents <i>31st March 2002:</i> 3 month review of all permanent residents <i>31st March 2002:</i> for all admissions (to 31 st March 2002) asap <i>1st July 2002:</i> all new non-urgent admissions < 2 weeks identification <i>31st Dec. 2002:</i> re-determinations for all existing (Oct 2001) residents 2003: <i>1st April 2003:</i> RNCC determinations start for LA supported residents <i>1st April 2003:</i> joint assessment & determination pre-admission for all	
	Study stage	Information source
Oct 2002 Building Capacity & Partnerships in Care DoH census of care home residents in PCTs Continuing Care HSC 2003/2006; LAC 2003/7	Stage 1 June-Oct 02	Stakeholder interviews: Regional, (Strategic) Health Authority, Primary Care Trust, Care Home stakeholders
	Stage 1 June-Oct 02	Co-ordinator/ lead nurse questionnaire A
	Stage 1 June-Oct 02	Registered nurse (RN) involved in RNCC determinations questionnaire B
	Stage 1 June-Oct 02	Independent homes key staff questionnaire C
	Stage 2 Nov 02-Mar 03	Co-ordinator/ lead nurse & RN questionnaire AB
	Stage 2 Nov 02-Mar 03	Care home key staff questionnaire CC
	Stage 3 April –June 03	Qualitative locality interviews

3.2 EARLY IMPLEMENTATION OF NHS FUNDED NURSING CARE

3.2.1 Regional role in initial preparation for RNCC determinations

<p>Regional role in initial preparation for RNCC determinations. The main findings were:</p> <ul style="list-style-type: none"> At the time of implementation of FNC, regions (who were charged with the initial FNC implementation role) were being disbanded. Thus, a rapid transfer of FNC responsibility, including the delivery of training, the management of determinations, and budgetary management, had to be made to PCTs. The later interviews with regional, PCT, and SHA stakeholders suggested some lack of clarity as to who held the responsibility for continuing monitoring and quality assurance of FNC. The newly created SHAs were also not referred to by other stakeholders as having any particular FNC responsibility.
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At the outset in 2001 the Department of Health identified a number of named NHS Executive Regional Office contacts for the implementation of NHS funded nursing care legislation. In England, 25 individuals were identified as FNC 'champions'. Their brief was to initiate and oversee implementation against a fixed timescale, as shown in the Table 3.2 above. Once individuals were identified, two half day's training (An introduction to RNCC) were offered at the Department of Health; usually, only one representative from each region was funded for travel and the study day.

Stage 1 depth interviews with regional leads identified a number of specific roles with regard to implementation. These included ensuring that PCTs identified personnel (lead nurses/ co-ordinators) to manage the RNCC determination process, and to whom funds could subsequently be allocated for NHS FNC. The regional champions also had direct responsibility for training the PCT lead nurses, with a small budget set at regional level for this purpose. This was then to be followed by the PCT leads themselves implementing cascade training for the RNs designated to carry out determinations, making use of the DoH web site and supervised determinations (i.e. by example and using documentation available from DoH).

"Identified project managers were responsible for training lead nurses or identified nurses in post and this was followed through by cascade training using the DoH web-site document on RNCC tool and two supervised determinations" {stage 1 regional interviewee}.

Regional champions also had a role in collating information on the number of determinations completed and communicating this to the DoH to help future planning, although this role was transient:

"Regions were responsible for producing some census information for DoH as snap shots to determine the budgets for future years" {stage 1 regional interviewee}.

"Statistics that were maintained at region for first round of initiative were all relayed to DoH. These statistics are not now available and data bases are no longer completed (relevant people e.g. nurse executives, budget managers have moved to different posts)" {stage 1 regional interviewee}.

During the initial period of implementation, regions were being disbanded. By the time of interview (some of which were conducted in October 2002), all those interviewed confirmed that, although regions had initially been charged with ensuring efficient implementation of NHS FNC, this responsibility had rapidly been transferred to PCT level. None mentioned SHAs as having an involvement. As well as delivering training, other transferred responsibilities included the management of determinations and budgetary management as shown in the following comments:

"region did originally have a web-site for each budget e.g. FNC/ training, continence/ specialist equipment but it is no longer running. There is no need, as PCTs have taken it [*FNC*] on board" {stage 1 regional interviewee}.

"The responsibility for managing FNC is at PCT level" {stage 1 regional interviewee}.

Interviewees were less clear about who had continued responsibility for monitoring and quality assurance. In principle, management and monitoring of the budget for NHS funded nursing care was to be one of the roles of the PCT *nursing home co-ordinator*, and monitoring the quality and consistency of RNCC determinations that of the *lead nurse* (see chapter 1).

"All the Trusts are developing audit mechanisms to check the decision making in RNCC" {stage 1 regional interviewee}.

"It will be interesting to see how nursing standards are monitored" {stage 1 regional interviewee}.

3.2.2 PCT early implementation role in RNCC determinations

(i) PCT co-ordinator/ lead nurse roles and division of duties

PCT co-ordinator/ lead nurse roles and division of duties. The main findings were:

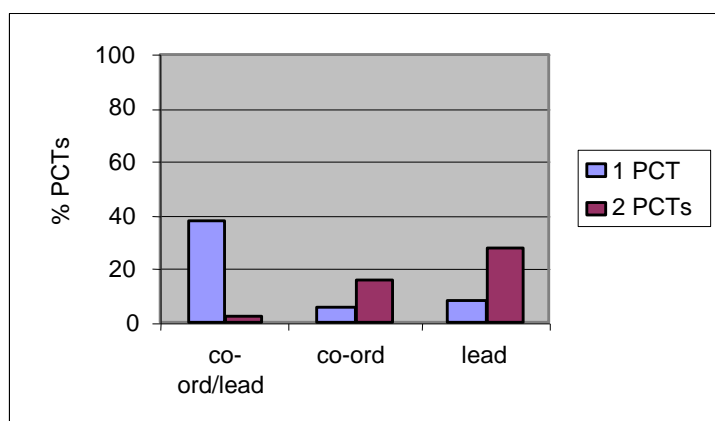
- The stage 1 survey (questionnaire A) and stage 2 survey (AB) both indicated that a significant number of respondents held a combined co-ordinator/ lead nurse role. Individuals with a combined role almost all had responsibility for only one PCT, whereas those with separate roles were more likely to be working across two or more PCTs.
- Respondents with responsibility for more than one PCT were slightly more likely to be able to identify a SHA person with involvement in QA, leading good practice or training. Whereas, those with responsibility for only one PCT were more likely to identify their SHA as having an involvement in finance. Overall, although there was some indication of SHA involvement by March 2003, this was only reported by fewer than two-fifths of PCTs.
- In terms of their roles, lead nurses were more likely than co-ordinators to be involved in supervision, carrying out determinations, and RNCC training but were less likely than co-ordinators to be involved in RNCC budget management. Whereas, staff with a combined function were most likely to describe roles such as supervision of determinations, RNCC training, and budgetary management. A majority of respondents reported that they were responsible for the maintenance of determination records, although in four out of ten cases, more than one person was involved.

At the time of the later stage 1 interviews (October 2002), responsibility for NHS FNC clearly lay with PCTs. The first tranche of PCTs had been established in October 2001 and the second became operational in April 2002. At the outset of FNC implementation in October 2001 PCTs and, where these were not fully operational HAs, had been asked to either identify two individuals to take the roles of *nursing home co-ordinator* and *lead nurse*, or to select someone who could fulfil both roles.

There was limited information available on the actual approaches adopted by PCTs to FNC staffing. Although each PCT was expected to identify up to two nurses, responses to the stage 1 survey (questionnaire A) indicated that a significant number of respondents (41%) described themselves as having a combined co-ordinator/ lead nurse role. The remainder responding on behalf of PCTs had a separate role; 37% were co-ordinators and 22% lead nurses. Interestingly, one in five respondents (21%) reported that they were responsible for *more than one PCT*, with the maximum number being 6 PCTs for those with a co-ordinator role and 5 PCTs for those with a lead nurse role.

As shown in Figure 3.1, of the individuals with responsibility for only one PCT almost all (92%) had a combined co-ordinator/ lead nurse role. Conversely, those with separate roles, especially lead nurses (31%), were more likely to be working across two or more PCTs. Responses to the stage 2 survey (questionnaire AB) confirmed that those who have a combined (co-ordinator/ lead nurse) role were more likely to report that they were responsible for only one PCT (78%).

Figure 3.1*: PCTs covered by combined (co-ordinator/ lead nurse) or separate posts



* Stage 1 survey (questionnaire A)

It would appear therefore that the model emerging in PCTs following implementation of FNC was primarily that of two separate roles. However, a significant minority of PCTs reported a single member of staff adopting a combined role, in which that individual usually had responsibility for only one PCT. Staff in these combined roles were not always happy, however, with all aspects of their role, particularly finance:

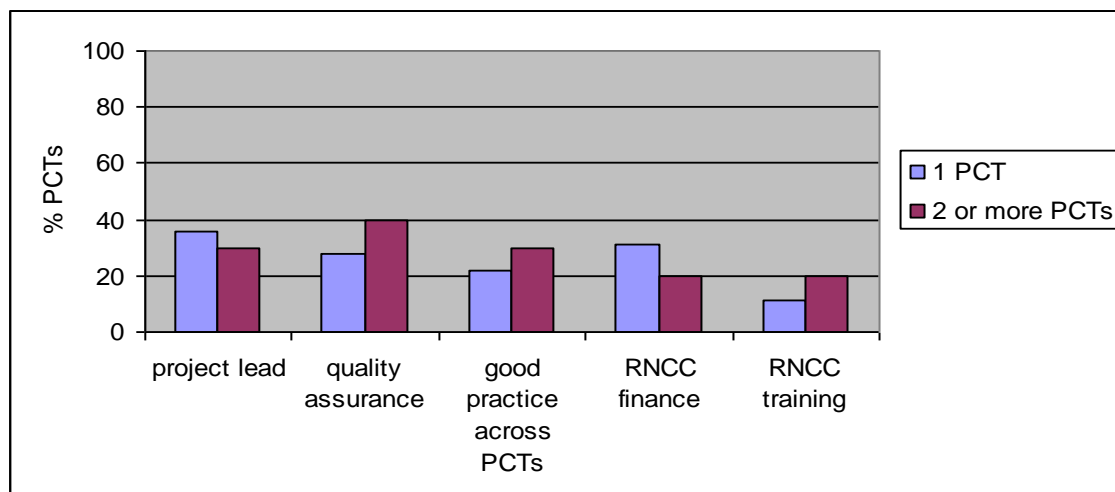
"Lead nurse now shares dual role of Nursing home co-ordinator - does not like the finance issues"
{stage 1 PCT interviewee}.

In some instances it would appear that responsibility for several PCTs grew out of FNC implementation originally being the responsibility of the HA because the PCTs were not in existence at the start of implementation:

"We had already assessed all the self funders for nursing homes as part of our old role in HAs" {stage 1 PCT interviewee}.

When PCT co-ordinators/ lead nurses/ RNs were asked about the emerging role of SHAs (stage 2 survey, questionnaire AB) only one in three (36%) said that there was a named person in their SHA who took an active role as a project lead (see Figure 3.2).

Figure 3.2*: Emerging SHA roles in aspects of NHS Funded Nursing Care



* Stage 2 survey (questionnaire AB)

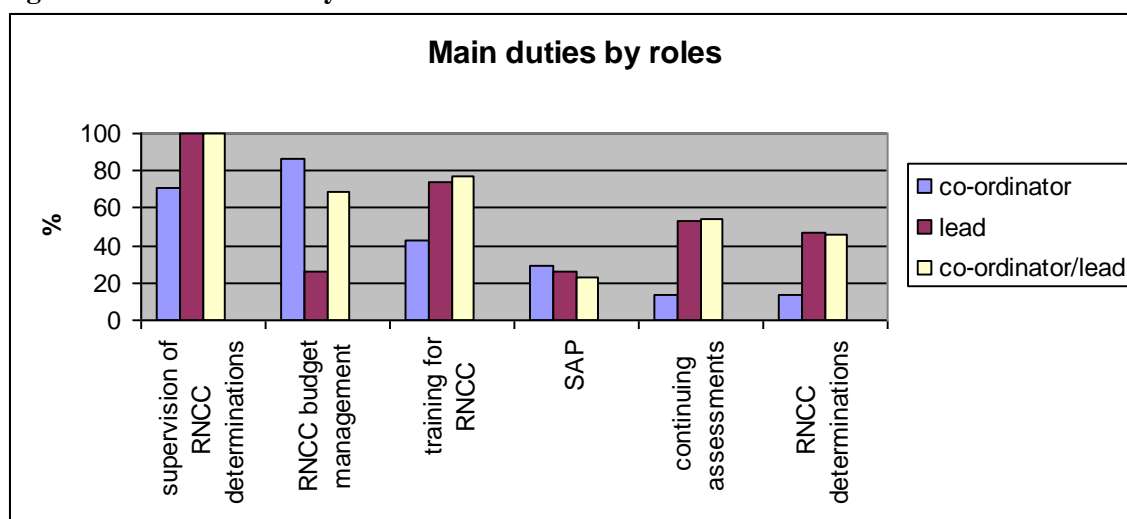
** More than one role possible

In terms of other SHA roles, a similar proportion identified an involvement in RNCC quality assurance (15/47 32%), in RNCC finance (13/47 28%), in leading good practice (11/47 23%), and relatively few in RNCC training (7/47 15%). Respondents with responsibility for more than one PCT were slightly more likely to be able to identify a person with QA, leading good practice or training involvement. Nurses with responsibility for only one PCT were more likely to identify their SHA as having an involvement in finance.

Thus, although there was some evidence of SHA involvement by March 2003, this was only reported by a minority of PCTs (<40%).

In terms of division of duties, PCT staff reported different activities in the stage 2 survey (questionnaire AB), depending on whether they had a combined role or not. These patterns of activities in relation to NHS FNC are shown in Figure 3.3.

Figure 3.3* Main duties by role in PCTs



* Stage 2 survey (questionnaire AB)

It had been indicated by the DoH that the main duties of the *nurse co-ordinator* should include: RNCC budgetary management; complaints and appeals; and liaison with local care homes, social services and RNs carrying out determinations. The main duties of the *lead nurse* should include: training of RNs carrying out determinations; monitoring the quality and consistency of determinations; and providing professional nursing advice to care homes about the conduct of determinations. Furthermore, advice from the Department of Health in 2001 indicated that lead nurses were to provide professional nursing advice to care homes about the carrying out of determinations; and oversee training of these RNs (Department of Health (2001), Guidance on Free Nursing Care in Care Homes).

Co-ordinators were most likely to report their main duties as budgetary management, supervision of RNCC determinations and training for RNCC. They indicated that budgetary responsibility, that ensured funding was correct, was shared with a number of others, including lead nurses, district nurse team leaders, administrators and secretaries. In contrast, lead nurses reported their three main roles as supervision of determinations, RNCC training and continuing assessments. Where separate roles exist, lead nurses are more likely than co-ordinators to be involved in supervision and RNCC training than those with a co-ordinator role; whereas they are less likely to be involved in RNCC budget management. A significant percentage of lead nurses (47%) also reported that they carry out determinations.

Staff with a combined function (28% of all respondents) were most likely to describe roles such as supervision of determinations, RNCC training, and budgetary management. However, almost half (49%) of all respondents also reported carry out determinations. In addition, the majority of respondents (55%) reported that they are responsible for maintenance of the determination records, although more than one person was responsible in 41% of PCTs. Only 10% indicated that records were the responsibility of an administrator.

The overall reported level of involvement in SAP was low (19%), although the survey was undertaken in the early stages of implementation (November 2002 vs April 2003). Other duties reported less frequently by co-ordinators/ lead nurses included: dealing with complaints and reviews; and responsibility for equipment.

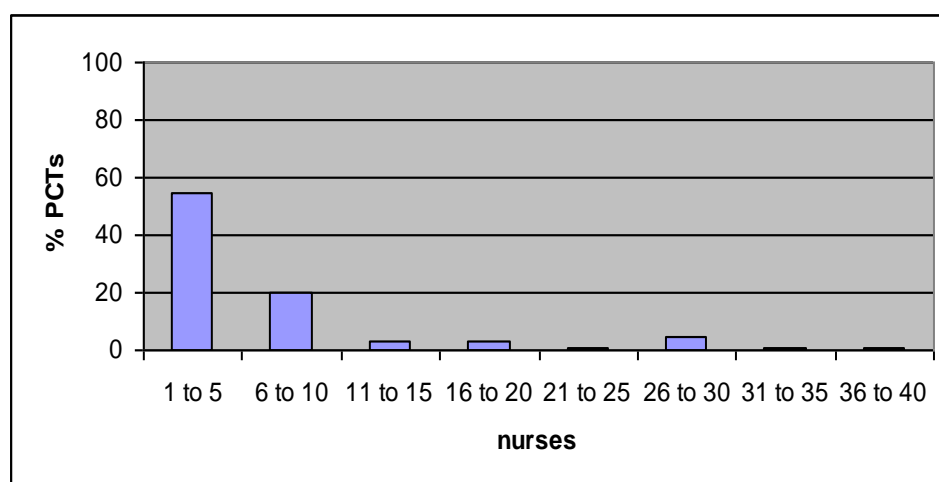
(ii) PCT staff undertaking RNCC determinations

PCT staff undertaking RNCC determinations. The main findings were:

- Qualitative evidence indicates that the initial approach to FNC implementation for self funded residents focused on completing tasks by the set target dates, and not on sustainable systems. Important factors appear to have been the lack of clarity about budgets to cover staff time and training, and local factors related to perceptions of 'spare capacity' among existing staff.
- These factors could have influenced the number of RNs and the amount of their available time used in completing the required number of determinations, and explain why some co-ordinators/ lead nurses reported that they were undertaking *all* the determinations themselves, whereas others reported specifically that they had excluded themselves from the process.
- Survey responses show that PCTs with the largest number of determinations to carry out appeared to rationalise and use fewer staff, and this pattern remained unchanged in the subsequent period.
- In first 6 month period, the PCTs reported completing an average of 22 determinations per month, including first determinations for existing (Oct 2001) self-funding residents, and 3 month re-determinations of existing self-funding residents. In the second 'steady state' phase (i.e. post April 2002) when new self-funding admissions were to be addressed, the number of determinations per month carried out by PCTs fell to less than half those in the first 6 months.
- Co-ordinators/ lead nurses were most likely to identify that G grade RN nurses were employed to conduct determinations. However, qualitative interview data indicated that this pattern was changing over time, with lower grade staff being trained for this role.
- Although some qualitative evidence suggested that RNs undertook determinations for residents with mental impairment, just over half of the PCT respondents indicated that a registered mental nurse (RMN) was *usually or always* involved in such determination, although in a further one third of PCTs, this was reported to be only *sometimes* the case.

Respondents to the stage 1 survey (questionnaire A) generally indicated that several nurses were involved in undertaking RNCC determinations in their PCT. Figures ranged from 1 to 40 RNs (median 4). Most PCTs identified 10 or fewer staff, as shown in Figure 3.4.

Figure 3.4: Percentage of PCTs and number of nurses



* Stage 1 survey (questionnaire A)

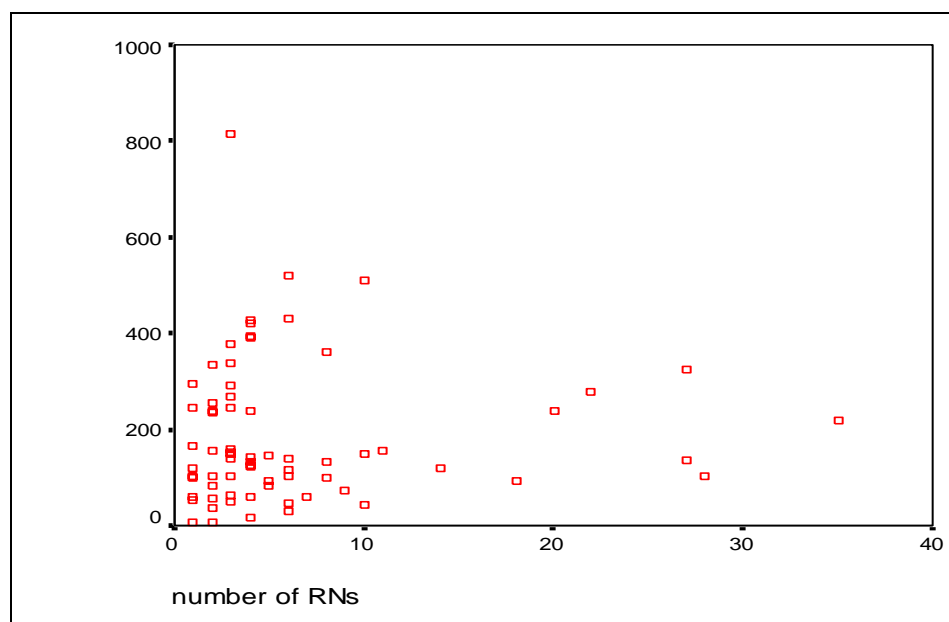
There was evidence from stakeholders that for the first phase of FNC an 'all hands to the wheel' approach had been adopted for operationalising the implementation of RNCC, with the main aim being to meet the target dates, shown in the following comments:

"First round implementation was very speedy. No choice it just had to be done" {stage 1 SHA interviewee}.

"First round was mainly a paper exercise with care home managers and case notes because of time limitations" {stage 1 PCT interviewee}.

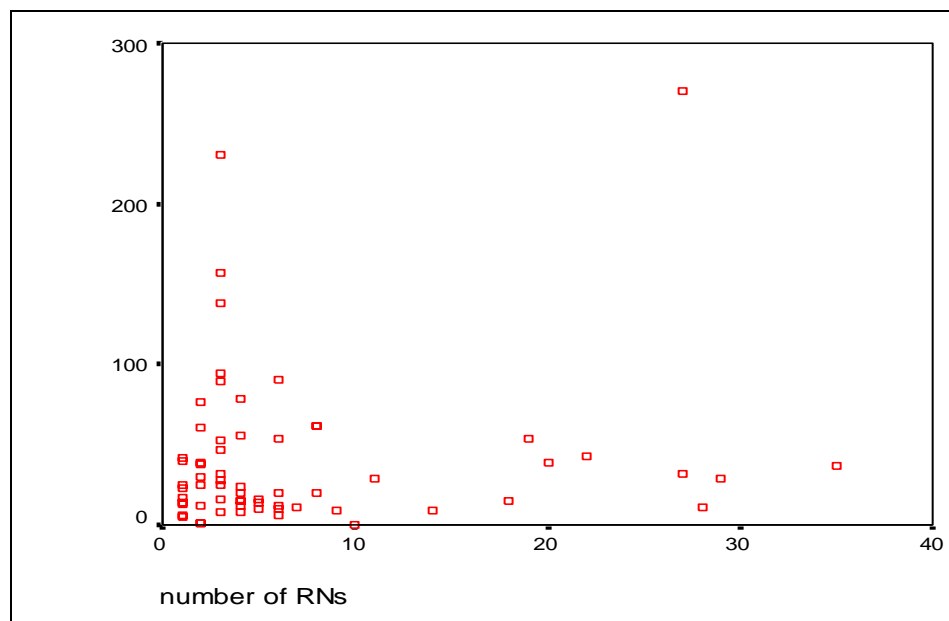
There was a negative but not significant correlation between the number of nurses and the number of care homes' beds per PCT (Pearson 2-tailed rho -0.107, $p < 0.38$). There was also no statistical relationship between the number of RNs reported as carrying out determinations during phase 1 of the implementation (October 2001 to 31st March 2002) and the number of determinations that were undertaken (stage 1, questionnaire A). In fact, those PCTs with the largest number of determinations to carry out appeared to be using fewer staff (see Figure 3.5). This pattern remained unchanged in the subsequent period (see Figure 3.6).

Figure 3.5: No. of RNs vs No. of determinations per PCT: 1st Oct 2001 to 31st March 2002



* Stage 1 survey (questionnaire A)

Figure 3.6: No. of RNs vs No. of determinations per PCT (1st April 2002 to 30th June 2002)



be followed locally. The nurses who are most likely to be designated will be highly experienced' (NHS Funded Nursing Care Practice Guide and Workbook DoH August 2001). At one extreme, some co-ordinators/ lead nurses reported that they were undertaking *all* the determinations themselves because of pressures on district nurses, whereas others reported specifically that they had excluded themselves. It appeared that where larger numbers of determinations were undertaken, there were likely to be fewer, more dedicated RNs undertaking these:

"I [*the lead nurse*] did all 94 first round determinations as there was no time or funds to train others" {stage 1 PCT interviewee}.

"None of our district nurses do determinations. They have enough to do and are all exhausted. There is no recognition for the extra time involved in carrying out determinations" {Stage 1 PCT interviewees}.

"All district nurses in PCT. Lead nurses should not be doing determinations. Who will do appeals to outcomes?" {stage 1 PCT interviewee}.

"Whoever is trained to do it" {stage 1 PCT interviewee}.

There was reasonable consistency in terms of the grade of staff selected to undertake determinations. Respondents to the stage 1 survey (questionnaire A) were most likely to identify that G grade nurses were used (70%). Other grades, usually in combination with G grade nurses, included F grade (61%); E grade (23%); and 3% of PCTs involved H grade nurses. Almost half the RNs (questionnaire B) described themselves as G grade (45%); the remainder were F grade (18%), E grade (10%) and 'Other' 8%. Co-ordinator/ lead nurses reported that one in four PCTs (26%) also employed 'other' grades usually continuing care nurse/ facilitators. There was some indication that this pattern was changing over time, with lower grade staff being used:

"All 'G' grades at first round but 'E's and 'F's will do reviews and LA residents" {stage 1 PCT interviewee}.

"We are training F's and E's for the re determinations" {stage 1 PCT interviewee}.

In terms of determinations for residents with mental health conditions, especially elderly mentally ill (EMI) individuals, there was variability in the use of mental health trained nurses, with several PCTs reporting determinations were carried out by RNs. RNs reported (Questionnaire B) that only 3% (5/161) of them were community psychiatric nurses (CPNs) and only one RN was mental health trained. Co-ordinators/ lead nurses (Questionnaire A) did not see lack of training in mental health as a barrier to carrying out determinations:

"Our RNs are happy to determine EMI residents using professional judgement. They are trained to assess" {stage 1 PCT interviewee}.

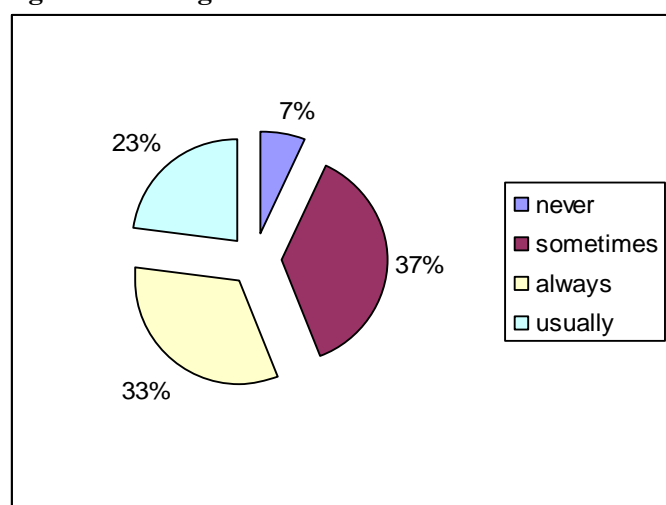
"EMI residents may be determined by mental health nurses but most RNs do not have a problem assessing EMI residents. They are used to assessing dementias" {stage 1 SHA interviewee}.

In some areas staff had been able to capitalise on an already established team:

"[we have] team of three trained staff. Specialist nurses for adult continuing care. We also have CPN nurses trained in determination process. This group has been running since 1994 and have always been involved in assessing for social services and self funders so transition was facilitated" {stage 1 PCT interviewee}

By the time of the stage 2 survey (questionnaire AB), however, only half of respondents (56% of PCTs) indicated that a registered mental nurse (RMN) was *usually or always* involved in determinations with EMI residents (see Figure 3.7).

Figure 3.7*: Registered mental nurse involvement in determinations with EMI residents



* Stage 2 survey (questionnaire AB)

It has been reported by the Alzheimer's Society (*Long Term Care: Statement by Royal Commissioners 2003*) that 75% of people needing long term care will have the disease or other forms of dementia, but because their problems are behavioural, a different type of support is needed and most have been placed in the lowest band in England. There are clearly issues yet to be resolved for dementia sufferers in relation to RNCC funding.

3.2.3 Strategic Health Authorities' emerging role

Interviews with stakeholders in the developing Strategic Health Authorities, which only became operational in October 2002, confirmed that SHAs were in flux at that stage and not directly involved in FNC; in fact one third of SHAs referred us directly to PCTs for information.

"You are ringing at the very worst time. No-one is appointed yet. No nurse in post at present time. Ring back in a few weeks" {stage 1 SHA interviewee}.

"Ask at PCT level. This [*Older People's lead*] is a new post so I may be involved at a later date" {stage 1 SHA interviewee}.

Although SHAs did not always have a FNC stakeholder (Older People's Lead/ Director of Nursing) in post, comments from those who did have someone in post indicated that these new organisations expected to adopt a monitoring/ supporting role for PCTs. As part of their accountability role for the performance of PCTs to the DoH, it was anticipated that this would include the FNC initiative.

"Our role is performance monitoring the impact, progress and expenditure for initiatives at PCT level" {stage 1 SHA interviewee}.

"There is no actual data collected at SHA level for FNC although we may eventually ask for it but we have no mechanisms in place at this time" {stage 1 SHA interviewee}.

SHAs appeared not to have taken FNC on board at the time of interview, not least because of the changes underway in PCTs as well as in the SHA, as illustrated in the following comment from an SHA stakeholder and reflecting the changes of '*Shifting the Balance of Power*':

"We can have access to data if requested through care home co-ordinators and lead nurses at PCT level. In this transition period SHAs try not to overburden the front line, including PCTs, with data collection" {stage 1 SHA interviewee}.

Stage 1 stakeholder interviews showed that, although SHAs were not budget holders for NHS FNC, they might be involved in supporting their PCTs in this role. Once again, those interviewed confirmed that NHS FNC was mainly "the remit of lead nurses for older people in PCTs, who had been designated as co-ordinator or lead nurse". However, two SHAs were advising their respective PCTs in relation to FNC. In some cases, co-ordinators/ lead nurses were also reported to be working with SHA finance staff:

"Nursing home co-ordinators liaise with [SHA] finance and pay care homes" {stage 1 SHA interviewee}.

Moreover, a number of the SHA stakeholders interviewed indicated that they were involved in planning ahead and that systems were in place for linking to Social Services:

"Some authorities [SHAs] have joint arrangements with Social Services and others have dedicated teams and infra-structure" {stage 1 SHA interviewee}.

However, by the time of the stage 2 survey (March 2003), when SHAs were more established, it was still only a minority of PCT staff who were able to report that their SHA had a named individual involved in NHS FNC (see Figure 3.2).

3.2.4 Training for RNCC implementation

Training for RNCC implementation. The main findings were:

- Stage 1 interview evidence suggested that the speed of implementation and the concurrent organisational changes in the NHS at the time of implementation impeded planned training for lead nurses, and co-ordinators/ lead nurses thought that insufficient consideration had been given to ongoing training.
- In contrast with stage 1 findings, the stage 2 survey responses from co-ordinators/ lead nurses and RNs indicated that training had been introduced smoothly in PCTs, although qualitatively it was suggested that training should be extended to care homes to help them clarify and distinguish RN nursing care from personal care needs, and to create greater reliability for information gained from care home documentation.

(i) Training of PCT co-ordinators/ lead nurses

As reported in section 3.2.1, it was planned that regional FNC project leads would be responsible for identifying and training co-ordinators/ lead nurses as the first stage of implementation. These PCT/HA staff would then be responsible for cascading training to all RNs undertaking determinations, making use of the DoH web site and supervised determinations.

"Lead nurses had 2 part days regional training" {stage 1 regional interviewee}.

"The DoH has supplied internet information about RNCC determinations" {stage 1 PCT interviewee}.

However, the speed of implementation and the organisational changes underway in the NHS at the time meant that the planned training for lead nurses was not always possible:

"Many lead nurses were not in post at time of training. They self taught from the web plus professional accountability. Lead nurses trained the selected RNs who were to carry out determinations" {stage 1 regional interviewee}.

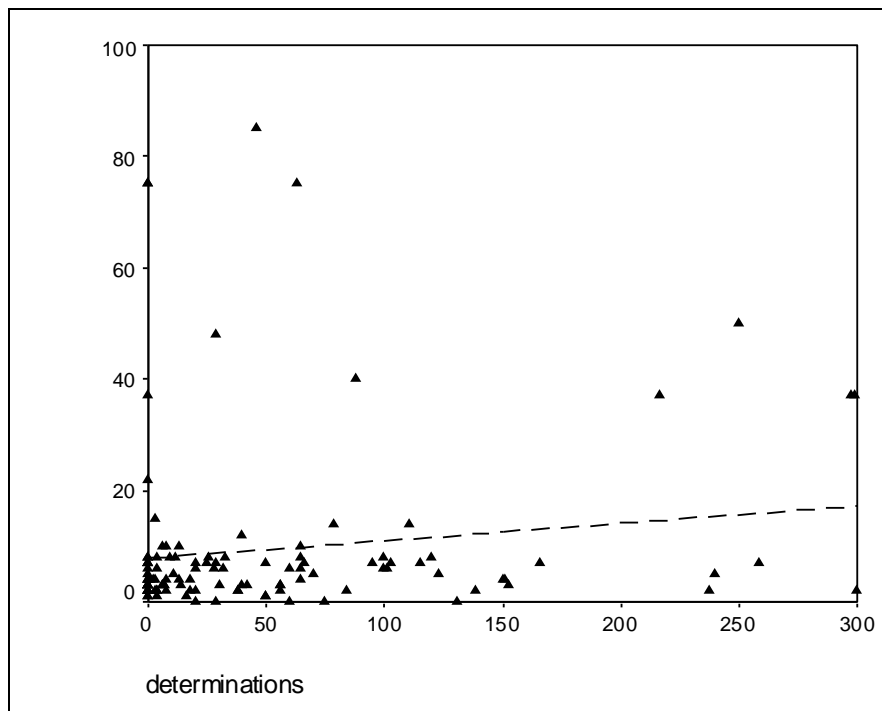
In a few areas, a broader training approach had been adopted:

"This HA is training nursing home staff/ hospital liaison staff and social services staff in understanding the determination process. This liaison is helping staff to understand 'what is nursing care' " {stage 1 SHA interviewee}.

(ii) Training of RNs undertaking determinations

In the stage 1 survey (questionnaire B), RNs undertaking determinations were asked to provide information on the number of hours of training they had received and the source of this training. The mean number, 10 training hours per RN, masked a very broad range (0-80 hrs).

Figure 3.8*: RN training hours vs number of determinations (October 2001-March 2002)

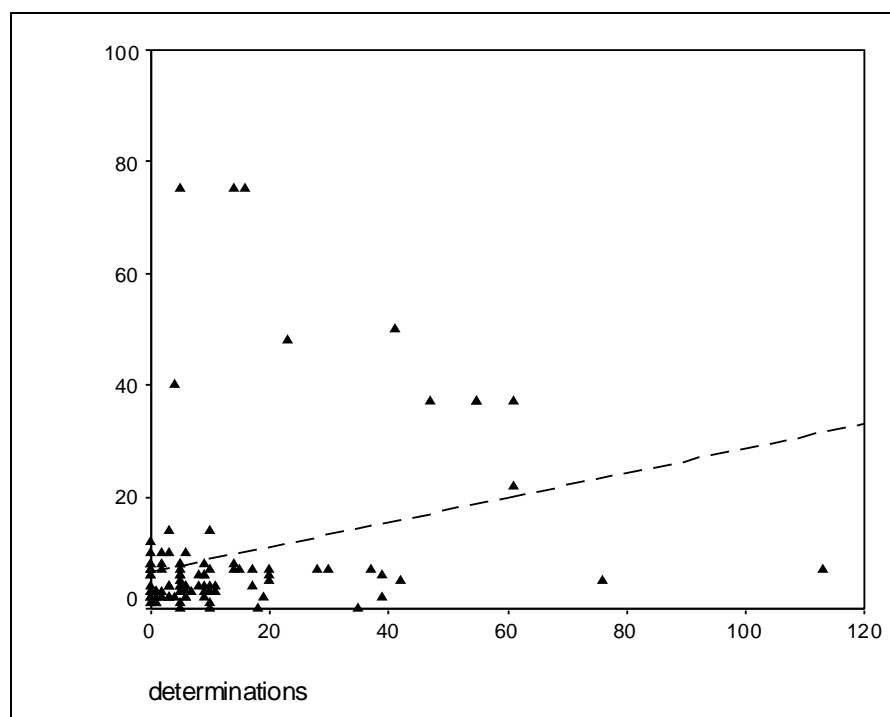


* Stage 1 survey (questionnaire B)

The number of hours of training individuals received was not linked to the number of determinations they subsequently carried out during phase 1 (existing residents), as shown in Figure 3.8 above; or to the determinations undertaken in phase 2 (see Figure 3.9 below). There were five individuals (3%) who reported they had received zero hours training; these nurses had undertaken a total of between 20 and 166 determinations in the two phases.

There was no significant correlation between reported training time and number of determinations (Pearson 2-tailed $p = 0.38$ and 0.1 respectively). This indicates that staff undertaking fewer determinations still received a similar amount of training. Since there is no guidance on the optimum length of training required, it is difficult to gauge whether this is adequate. Clearly, zero hours *formal* training would not be considered adequate. In their responses to the stage 2 survey (questionnaire AB), only two thirds (64%) of co-ordinators/ lead nurses/ RNs reported that they considered RNCC training had been *adequate* in their PCT.

Figure 3.9*: RN training hours vs number of determinations (April 2002-June 2002)



“Updated information within care plans should be encouraged to reduce questioning of staff regarding FNC determinations and reviews” {questionnaire AB}.

3.2.5 Funding of RNCC implementation

Funding of RNCC implementation. The main findings were:

- PCT stakeholder interviews in late 2002 consistently identified a lack of dedicated funding as an issue for FNC implementation at PCT level.
- Some RNs undertaking determinations indicated that because the conduct of determinations was not properly resourced, it should be undertaken by staff other than community nurses whose workload was already perceived as high.
- Lack of resource was given as a challenge in using mental health trained nurses for the undertaking of determinations.

The depth interviews with PCT stakeholder in late 2002 consistently identified a lack of dedicated funding as an issue for implementation at PCT level (i.e. for training of RNs, for nursing time to undertake determinations, for travel costs). This was illustrated by a large number of comments:

"No actual budget identified for this, provided from general 'pool' only" {stage 1 PCT interviewee}.

"Difficult to answer. Most district nurses have had extra responsibilities added to their remit with no remuneration" {stage 1 PCT interviewee}.

"[*funding*] not specified. To cover all aspects of funded nursing care" {stage 1 PCT interviewee}.

"No budget. It is all completed in community nursing time" {stage 1 PCT interviewee}.

This was reported to be causing some hardship:

"There wasn't any dedicated funding for doing this [*introducing RNCC*]. Our money that we are based on doesn't really meet the free nursing care obligation" {stage 1 PCT interviewee}.

In the stage 2 survey (questionnaire AB), co-ordinators/ lead nurses/ RNs confirmed that budgetary responsibility for RNCC determinations after April 2003 remained firmly with PCTs. The percentage of respondents who identified any SHA involvement was extremely low (4%).

Some RNs undertaking determinations felt quite keenly that because the conduct of determinations was not properly resourced, it should be undertaken by other staff:

"Specialist nurses should be employed by the government to undertake all the determinations. District nurses are already severely overloaded with work and the government should pay directly to their own staff if they want the job done" {stage 1 questionnaire B comment}.

In particular, lack of resources was causing problems in using mental health trained nurses for undertaking determinations:

"Some of our mental health trained staff are requesting remuneration for determinations and this is a problem as our district nurses are not paid for this role" {stage 1 PCT interviewee}.

The pressure placed on district nurses' time was emphasised by a number of respondents:

"It is a huge extra burden as determinations are extra work for all district nurses but we have no choice" {stage 1 PCT interviewee}.

3.2.6 Implementation of RNCC determinations for new residents

Implementation of RNCC determination for new residents: The main findings were:

- Shortly before the 1st April 2003 deadline for joint assessment and determination to be carried out pre-admission for all new residents (self- or LA- funded), fewer than half of the PCTs co-ordinator/ lead nurses and RNs who responded had a system in place for this, and no-one reported that determinations had been completed prior to admission. Of the determinations for new admissions, most were conducted within 14 days of admission.
- RNCC determination was not identified by anyone as a reason for delay in transfer to care homes. The main reason given for the delay in conducting determinations for new admissions was poor communication, and to a much lesser extent, a lack of time or staff.
- Those most likely to give notification of new admissions were given as social services personnel and liaison nurses for patients moving from hospital to care home, and social services for patients moving from own home to care home.
- The stage 2 survey of PCT nurses identified the most common reasons for delays in transfer to care homes in their PCT as 'waiting for a bed', or 'waiting for a bed in a specific home'. Apart from care home capacity, waiting for social services input and medical reasons were given by less than 10% of PCT nurse respondents.

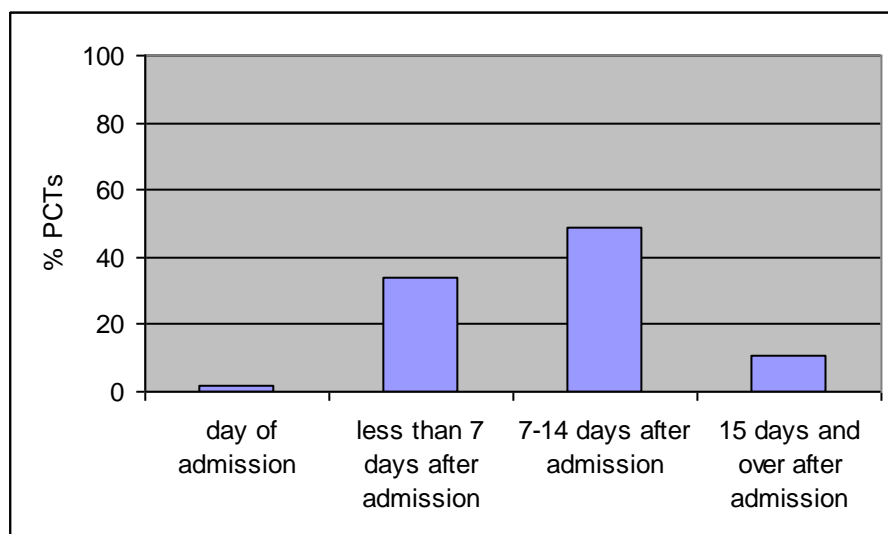
(i) Undertaking RNCC determinations for new residents

As well as completing RNCC determinations for their existing self-funding residents by the end of 2002, a target date for determinations to be completed *within two weeks of notification* for all such new non-urgent admissions was set at 1st July 2002. This was to be followed by joint assessment (SAP) and determination pre-admission for all new residents (self- or LA- funded) by 1st April 2003 (originally April 2002) DoH guidance about implementation of SAP is on-going although consultation ended on 29th August 2003.

In fact, it was reported by co-ordinators/ lead nurses/ RNs in the stage 2 survey, (questionnaire AB) that systems were in place by March 2003 to ensure that determinations were carried out before home admission in fewer than half (44%) of PCTs. A further one third (35%) reported that systems were being developed. Nine percent of co-ordinators/ lead nurses stated that they did not have systems in place and 8% did not answer this question. Thus by March 2003, shortly before the 1st April 2003 deadline for joint assessment and determination to be carried out *pre-admission* for all new residents (self- or LA- funded), fewer than half of the PCTs who responded even had a system in place for this. However, one third (34%) of PCTs reported they were completing determinations within 7 days of

admission (see Figure 3.10). No-one reported that determinations were being completed prior to admission, although one PCT stated that they were carried out on the day of admission.

Figure 3.10*: Timing of RNCC determinations for new admissions



* Stage 2 survey (questionnaire AB)

In terms of the earlier 1st July 2002 target date for determinations to be completed within two weeks of notification for all new non-urgent admissions, nearly all PCTs (85%) reported that they were achieving this target by March 2003. In the stage 1 interviews at the end of 2002, care home stakeholders themselves indicated that residents were being transferred directly into their care home before the notification of a need for determination, and that this might cause problems for the care home because payment would not be backdated:

"Assessment of new admissions is supposed to be undertaken before they are admitted. This is not happening in the majority of cases, and many PCTs are now refusing to pay for unassessed (sic) residents" {stage 1 Care Home (chain) interviewee}.

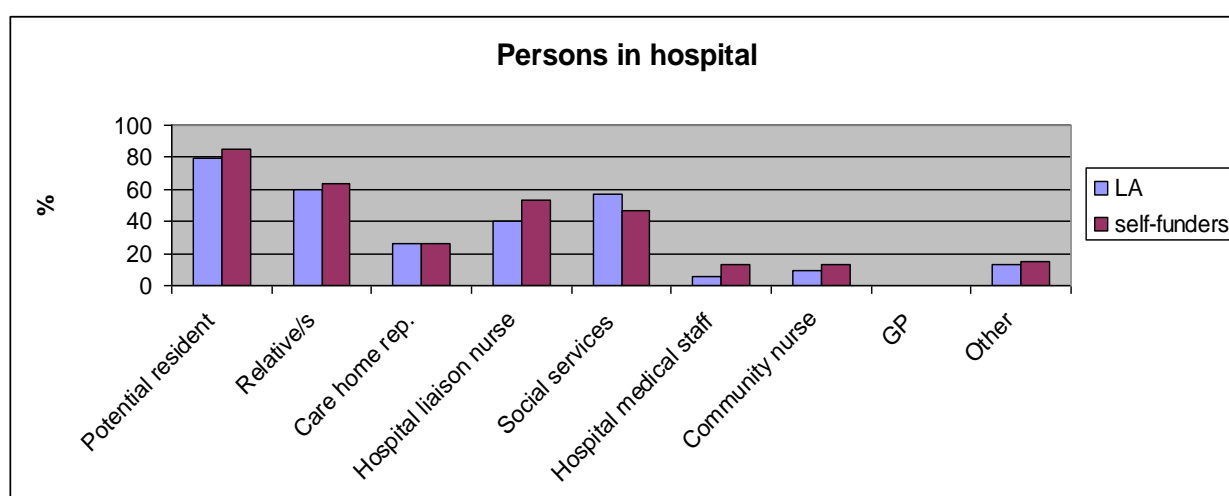
This was similarly confirmed by the responses of care homes' key staff to the stage 2 survey (questionnaire CC) where fewer than one in seven (14%) care home managers reported that determinations for new residents were being completed before admission to the home.

Co-ordinators/ lead nurses/ RNs were also asked in the stage 2 survey (questionnaire AB) for their opinion on what appeared to be the underlying cause of delays in undertaking determinations for new admissions to care homes in their PCT. Delays were mainly thought to be due to lack of communication (51%). Staff/ time pressure was less often an issue [lack of time (11%) or staff (9%)]. A few respondents identified other factors as the cause of delays such as: emergency admissions to homes, out of area transfers, acute wards not being considered appropriate for carrying out determinations, and reliance on care home managers to refer residents for determination.

ii) Notification of new admissions requiring RNCC determinations

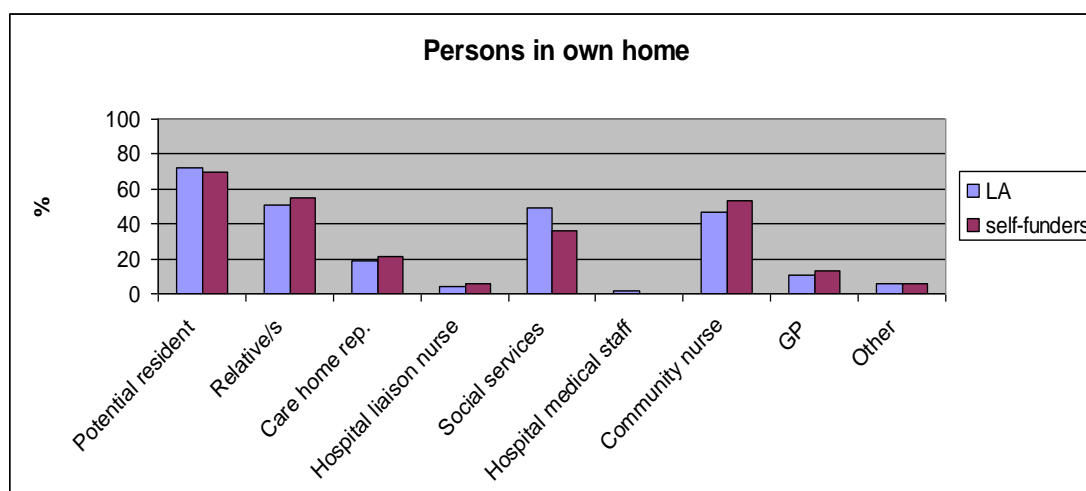
The major cause of delay in determinations was reported to be lack of communication (questionnaire AB) and co-ordinators/ lead nurses/ RNs were also asked to provide information on the professional groups involved in identification of new residents requiring RNCC determinations. For new admissions from *acute hospitals*, Figure 3.11 shows that the main professional group involved are Social Services staff (57% LA & 47% self-funders). Other people mentioned included the ‘complex needs’ disability team, for example. For new residents being transferred from their *own homes*, identification was also primarily via Social Services (87%) and liaison nurses (72%), as shown in Figure 3.12.

Figure 3.11* : Notification of new admissions (hospital) for determinations by % PCTs



* Stage 2 survey (questionnaire AB)

Figure 3.12* : Notification of new admissions (home) for determinations by % PCTs

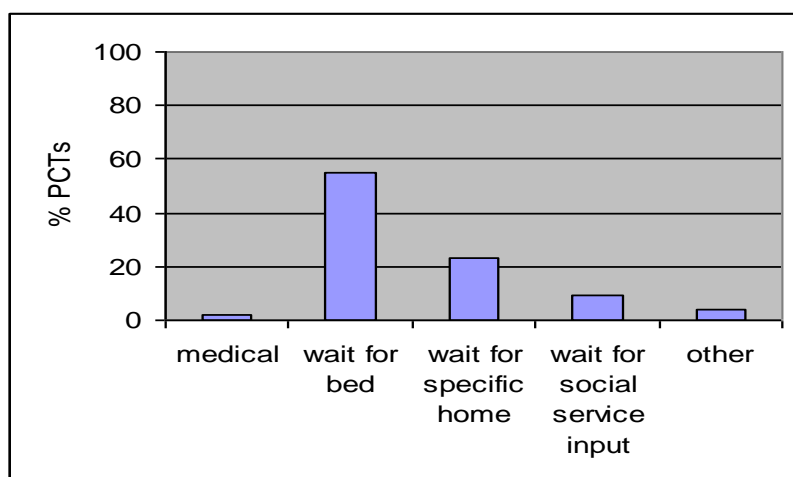


* Stage 2 survey (questionnaire AB)

(iii) *Impact of implementation of RNCC determinations on admissions to care homes*

As well as exploring the reasons for delays in undertaking determinations for new admissions, in the stage 2 survey (questionnaire AB) co-ordinators/ lead nurses/ RNs were also asked to identify the most common reason for delays in transfer to care homes in their PCT. Over three quarters (78%) identified waiting for a bed, with 23% specifying waits for a bed in a specific home, as the major delaying factor in their PCT (see Figure 3.13). Apart from care home capacity issues, waiting for social services input was cited by only 9% of PCTs and medical reasons by a further 2%. 'Other' reasons included delay by relatives in one PCT. Free text comments by respondents also mentioned the possibility that availability of funding, or lack of it, could change residents' or relatives choice of care home, and might thus delay admission. These responses indicate that Social Services are part of, but not the whole, dilemma. There are also capacity issues in care homes, which may be a more likely contributor to any delays.

Figure 3.13*: Main reason reported by care homes for delay in admission



* Stage 2 survey (questionnaire AB)

The conduct of RNCC determinations was **not** identified as a cause of delay in transfer to care homes by any PCT. This is presumably because determinations were not being carried out pre-admission. However, it appears that even though delays in transfer of new residents (from hospital or home) offer an improved opportunity to undertake both joint assessment and RNCC determination *pre-admission* for new residents, no PCT had been able to successfully implement this.

3.3 PROGRESS AND RESOURCES REQUIRED FOR DETERMINATIONS

Responses to the national survey indicate that, in general, good progress had been made towards meeting the various target dates set for implementation, apart from the last (determinations pre-admission). As pointed out earlier, these targets included, completing all RNCC determinations for existing self-funding residents by the end of 2001, undertaking a 3 month review of these by 31st March 2002, commencing (originally finishing) determinations for all local authority funded residents by 31st March 2003, and introducing joint assessment and determination pre-admission for all by 1st April 2003.

3.3.1 National progress with RNCC determinations (PCT views)

National progress with RNCC determinations (PCT views). The main findings were:

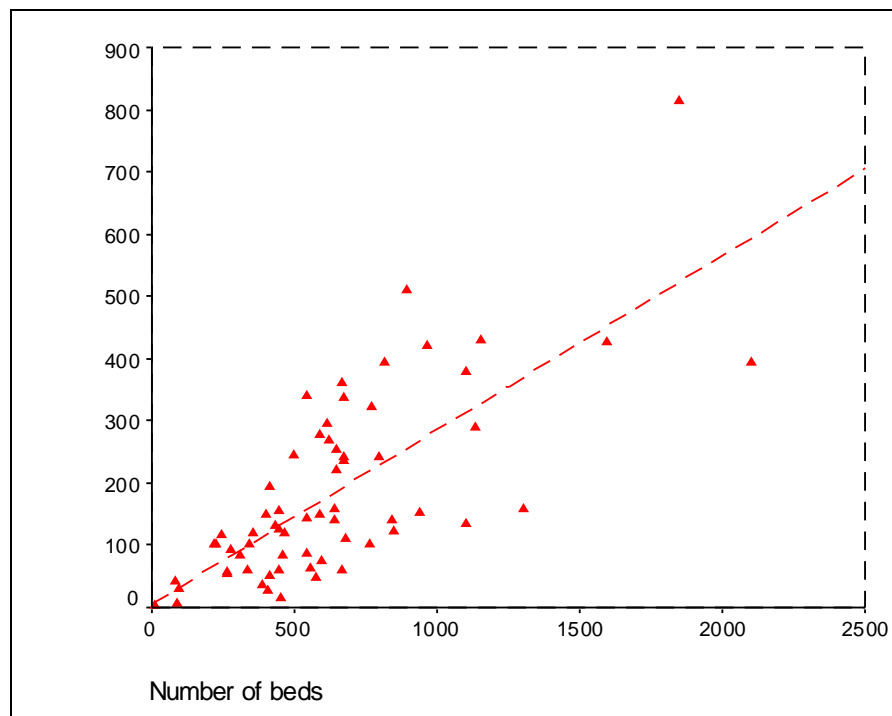
- PCTs differed in terms of the size of the task with which they were faced in undertaking RNCC determinations. The number of determinations undertaken in a PCT was linearly related to the reported number of care home beds in the area, although there was some spread.
- Eighty-six percent of responding PCTs indicated that all eligible residents had undergone determinations during Oct 1st 2001- March 2002. The PCTs that had not met this target date were not necessarily those with larger numbers of determinations to complete. NHS nurses similarly reported that three month follow-ups of self-funders were also up to date in four-fifths of PCTs.
- Where 3 month re-determinations were not up to date, the majority reported that this was due to lack of time or lack of available staff.
- Some two-thirds of PCTs' nurses had already completed all determinations for LA funded residents, approximately one month before the (revised) target date for commencing these determinations. Where PCTs indicated less than 100% completion rate, this was again reported to be due to lack of time and/or staff.

Inevitably, PCTs differed in terms of the size of the task with which they were faced in undertaking RNCC determinations. Responses from co-ordinators/ lead nurses to the stage 1 survey (questionnaire A) showed that the number of determinations carried out per PCT in the 6 month period (1 October 2001-31 March 2002) ranged from only 5 to 814 (median 129). As might be expected, the number of determinations undertaken in respondent PCTs was linearly related to the reported number of care home beds in the area, although there was some spread (see Figure 3.14). The median number of determinations per bed carried out during these 6 months was 0.28, but this figure varied between 0 and 1.16 per bed (equivalent to 2.32 per bed per annum; median 0.56).

Eighty six per cent of responding PCTs indicated that all eligible residents had undergone determinations during this period (stage 1 survey, questionnaire A). Figure 3.15 shows the number of determinations by number of beds in PCTs. Only 5% stated that not all their residents had undergone determination, 8% of respondents did not answer the question or did not know. Of the 5% whose residents had not all undergone determination (5 homes), there were only two homes which provided data on number of beds as well as number of determinations, 2,103 beds and 392 (17%)

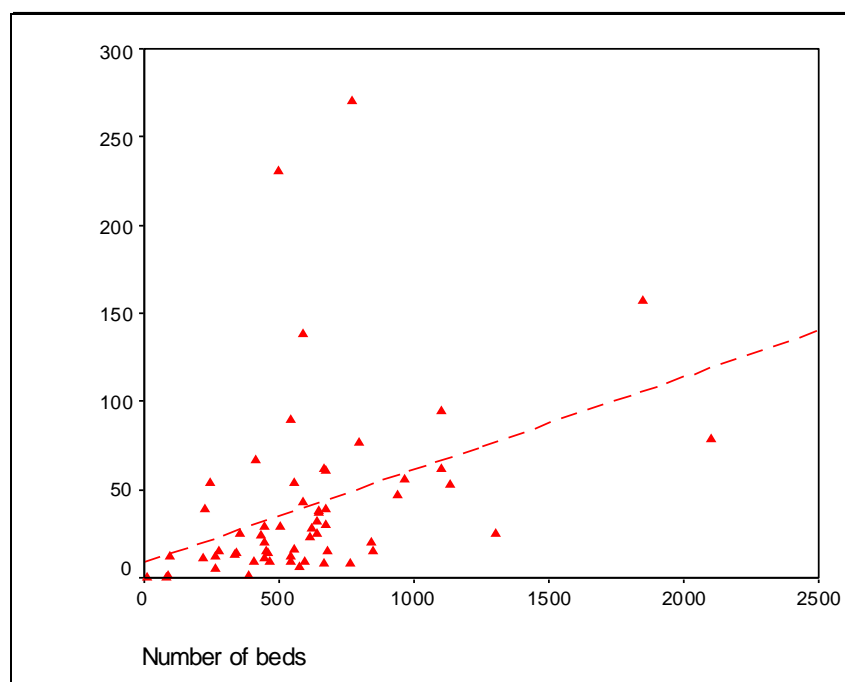
determinations, and 450 beds and 155 (34%) determinations respectively. Although this information was very limited, it provides some evidence that PCTs that had not met the target date were not necessarily those with a larger number of determinations to complete.

Figure 3.14* : Determinations vs care home beds in PCTs (1st Oct 2001 to 31st March 2002)



* Stage 1 survey (questionnaire A)

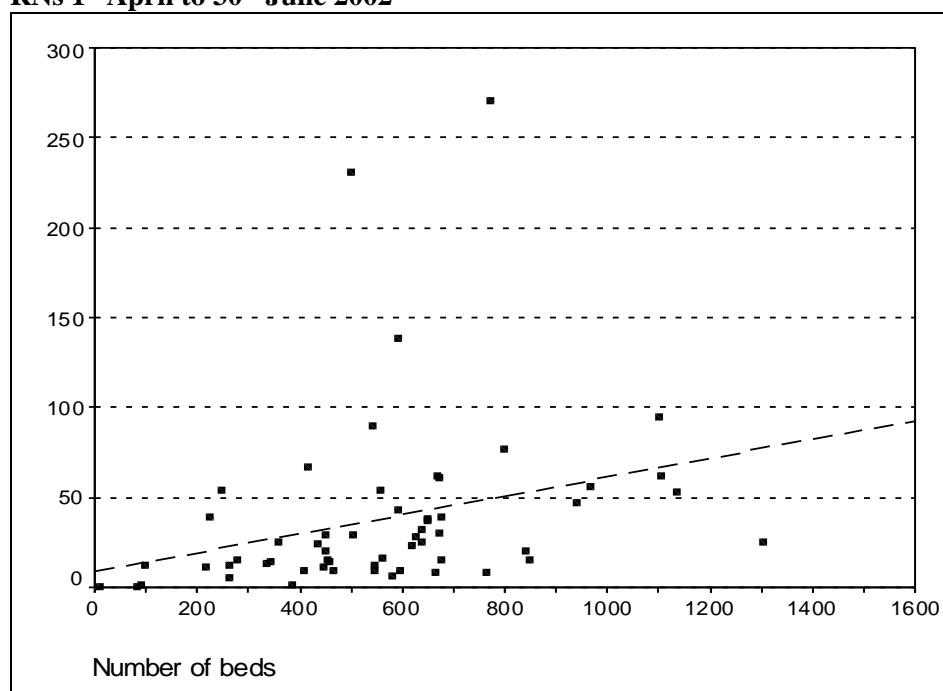
Figure 3.15*: Determinations vs care home beds in PCTs (1st April 2002 to June 2002)



* Stage 1 survey (questionnaire A)

Figure 3.16 shows a similar pattern based on co-ordinator/ lead nurse responses for the period April to June 2002 (questionnaire A). The median number of determinations carried out per PCT in this 3 month period was 23 (range 0 - 270). The median number of determinations per bed was 0.14 (range 0 - 1.16); in terms of determinations per annum per bed, this was equivalent to median 0.12 (range 0 - 4.64).

Figure 3.16*: Number of determinations vs number of care home beds reported by individual RNs 1st April to 30th June 2002



* Stage 2 survey (questionnaire AB)

In the stage 2 survey (questionnaire AB), NHS nurses similarly reported that three month follow-up of self-funders was up to date in 81% of PCTs. However, 12% of PCTs stated that it was not, while the remainder did not answer this question. Where 3 month re-determinations were not up to date, the majority reported that this was due to lack of time (75%) or lack of available staff (52%).

Finally, analysis of responses to the stage 2 survey (questionnaire AB) identified that 58% of PCTs had already completed all determinations for LA funded residents, approximately one month before the (revised) target date for commencing these determinations. In a further 23% of PCTs three quarters of determinations were complete, and 7% of PCTs had completed half.

The remaining 12% had completed one quarter or less. Where PCTs indicated lower than a 100% completion rate, this was once again reported to be due to lack of time and/or staff.

3.3.2 National progress with RNCC determinations (care home views)

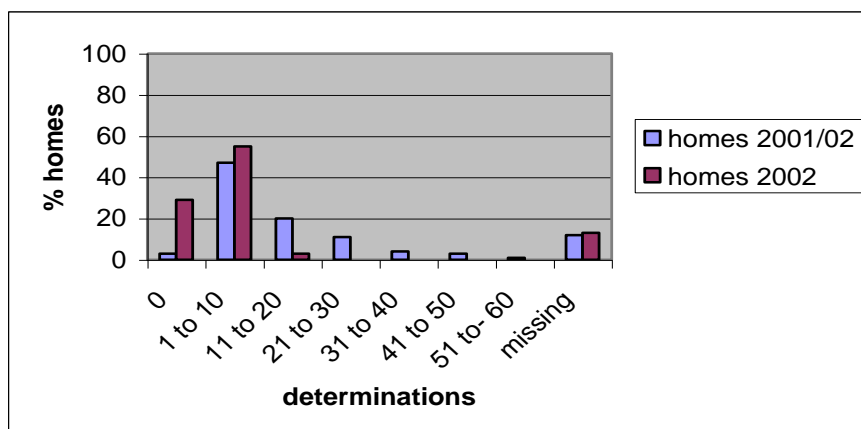
National progress with RNCC determinations (care home views). The main findings were:

- Evidence provided by care home respondents to the stage 2 survey (questionnaire CC) confirmed that good progress had been made by PCTs in meeting the target dates for self-funders and LA funded residents.
- However, 10% of care homes' staff said that their self-funding residents had still not undergone determination, over 12 months after the target date for completion.

In the stage 1 survey (questionnaire C), care home managers were asked about the number of determinations that had been carried out in their home for existing residents between 1st October 2001 and 31st March 2001, and for new residents between 1st April 2002 and 30th June 2002. Results are shown in Figure 3.17 for these two periods. Most care home managers reported fewer than 20 determinations in each time period (70% during the first time period and 84% in the later, shorter time period).

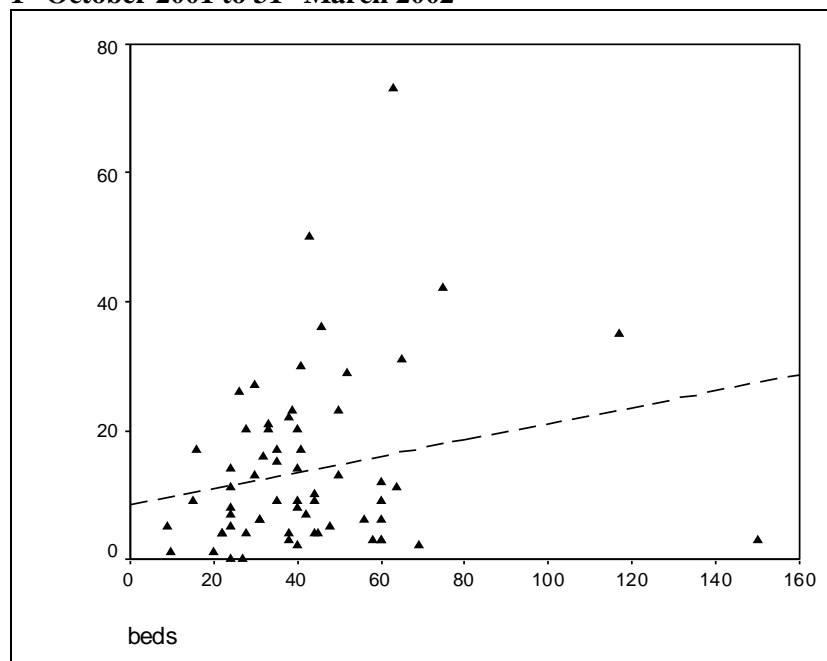
Figure 3.17*: Number of determinations in a care home

*Stage 1 survey (questionnaire C)



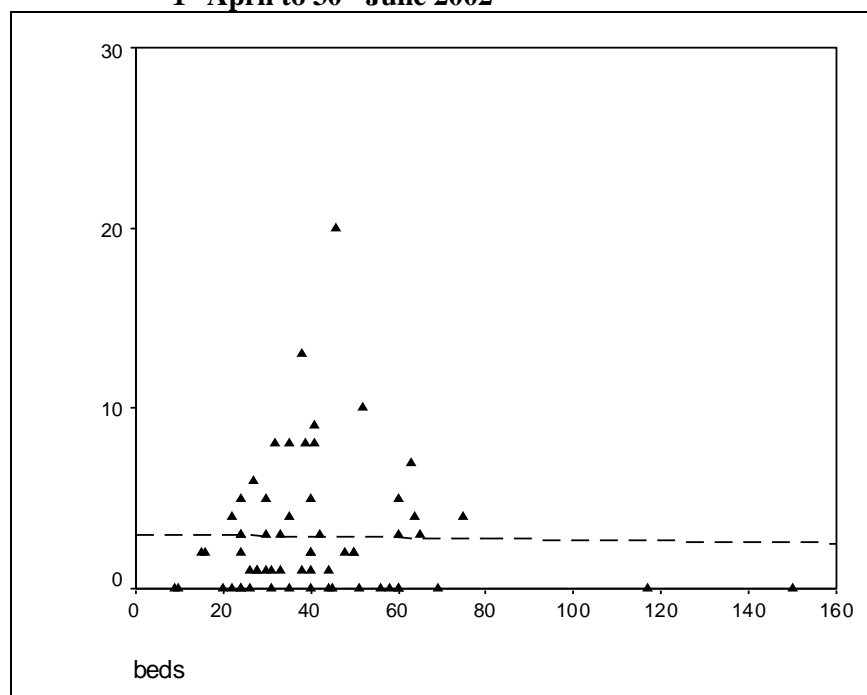
Figures 3.18 and 3.19 below demonstrate that the median number of determinations carried out per bed during the first 6 months period and the second 3 months period. Combining the number of determinations for both periods, the median number of determinations per bed was 0.44 (range 0.03 to 1.69). These compare well with the co-ordinator/ lead nurse figures.

**Figure 3.18*: Number of determinations vs number of beds in care homes
1st October 2001 to 31st March 2002**



* Stage 1 survey (questionnaire C)

**Figure 3.19*: Number of determinations vs number of beds in care home
1st April to 30th June 2002**



* Stage 1 survey (questionnaire C)

The evidence provided by care home respondents to the stage 2 survey (questionnaire CC) confirms that good progress had been made by PCTs in meeting the target dates both for self-funders and local authority funded residents. Care home managers reported that the majority of determinations had been completed for self-funders (86% compared with 81% of PCTs as reported by co-ordinators/ lead nurses at the same time). Over two thirds of care homes (69%) said that determinations for LA funded residents were also complete. However, 10% of care homes said that their self-funding residents had still not undergone determination, over 12 months after the target date for completion.

3.3.3 Introduction of the Single Assessment Process (SAP)

Introduction of the Single Assessment Process (SAP). The main findings were:

- By March 2003, only a quarter of PCTs had introduced SAP. Where it was carried out, more often respondents said that it was not undertaken at the same time as the determination for FNC.

By the time of the stage 2 survey (March 2003), only a quarter of respondents indicated that SAP had been introduced in their PCT (questionnaire AB). Fewer than half of these (11%) reported that RNCC determination was being carried out at the same time as SAP; more often (36%) it was reported that SAP was not carried out at the same time, usually because of the early stage of SAP development. Thus, as pointed out previously, PCTs were less advanced in terms of meeting the target of introducing joint assessment and determination pre-admission for all by 1st April 2003, and DoH guidance about implementation of SAP is on-going although consultation ended on 29th August 2003.

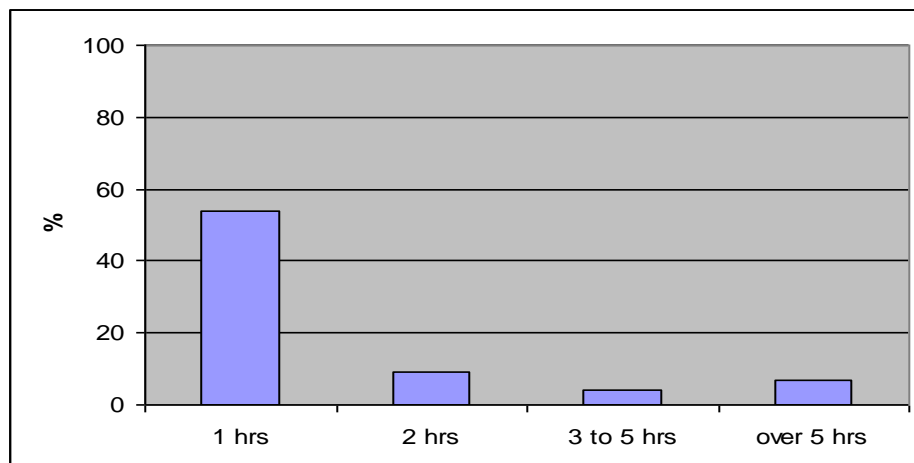
3.3.4 NHS time and resources required to undertake RNCC determinations

NHS time and resources required to undertake RNCC determinations. The main findings were:

- RNs undertaking a high number of determinations did not necessarily have more training hours.
- The median time per determination was estimated at 1 hr and excluded RN time for travelling to the care home; record keeping, etc; or senior staff time spent on RNCC budget management, training, supervision of determinations, appeals/ reviews, etc.
- Using national data on the number of determinations carried out in all 304 PCTs, approximately 130,000 per annum for self-funding and LA funded residents, an estimated mean annual cost of undertaking RNCC determinations is £9 million for all 304 PCTs, and estimated at approximately £30,000 per PCT.

Information provided by RNs in the stage 1 survey (questionnaire B) indicated that, on average, most (54%) were spending an average of one hour per determination (see Figure 3.20), with the remainder spending longer. These figures are based on determinations carried out between 1st April 2002 and 30th June 2002, by which time it was judged that RNs should be reasonably experienced in the process, and that any learning curve would be complete. The median time per determination is estimated at 1hr. This is the direct RN time spent on determinations. It does not include indirect time e.g. travelling to the care home, record keeping etc, or senior staff time spent on RNCC budget management, training, supervision of determinations, appeals/ reviews etc.

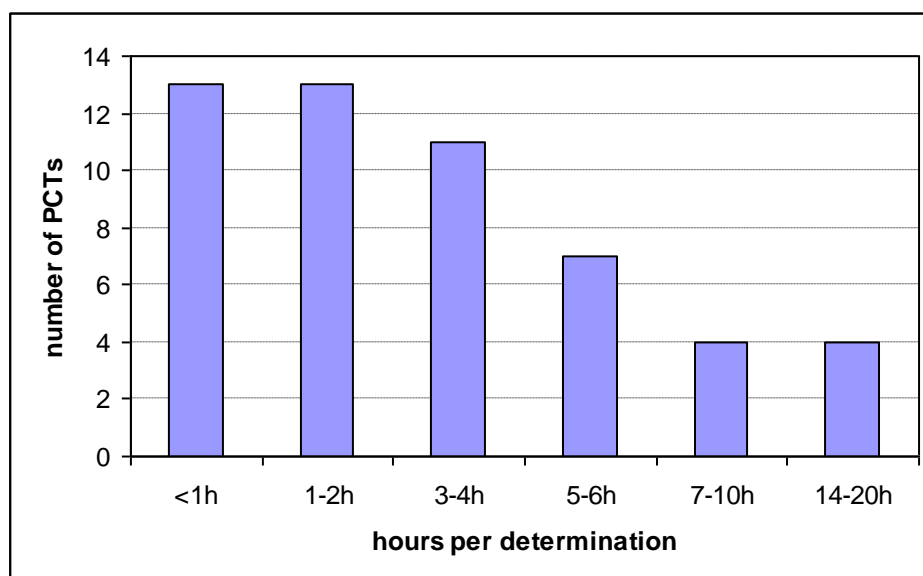
Figure 3.20*: Direct time per determination spent by RNs



* Stage 1 survey (questionnaire B)

Therefore, co-ordinators/ lead nurses were also asked to estimate (stage 1 survey, questionnaire A) the *total time* per week spent on determinations in their PCT. Figure 3.21 shows that estimates ranged from 1 hour to 111 hours, with a median value of 27 hours per week. When related to the number of determinations reported by their PCT, this equates to a median 3 hours (range 0.1 to 20) per determination, including co-ordinator/ lead nurse time as well as RN time. Thus, approximately twice as much time per determination is spent on travelling, monitoring etc, as carrying out the determination itself.

Figure 3.21 Estimated time spent per determination in PCTs



* Stage 1 survey (questionnaire A)

Annual re-determination costs

To calculate the costs incurred on an annual basis for nurses carrying out determinations in all the 304 PCTs, national data on the number of self-funding residents and LA residents in care homes are used (NHS Funded Nursing Care: 2002 Census of Residents of Care Homes Receiving Nursing care in England). The total number of eligible self-funding residents in England receiving nursing care funded by PCTs from 1 April 2003 was 41,580. The total number of care home residents receiving nursing care supported by Local Authorities was 88,684, giving a grand total of 130,264 residents in England.

First, we can assume that the most likely grade of staff undertaking determinations will be G grade nurses (see section 3.2.3 iii). Using the mid-point of the G grade nursing scale (£24,376 excluding discretionary points) gives a pro rata hourly rate based on a 38 hour week of £12 per hour (ca £15, including additional costs of National Insurance, pension etc). This is a conservative figure since some of the time dedicated to determinations is that of more senior staff who will be on a higher salary scale. Using the calculation above on the number of re-determinations carried out in all PCTs, estimated at approximately 130,264 per annum, it is possible to estimate mean annual cost to PCTs of undertaking RNCC determinations. This represent an approximate mean annual cost across all 304 PCTs in England of £2 million (£1,953,960) per annum.

These figures still exclude non-staff costs (e.g. travel costs) and support costs e.g. training. There appeared to be a general lack of budgetary information in PCTs on these. In response to the stage 1 survey (questionnaire A), only five respondents (6%) could provide a breakdown that included training and travel budgets; figures provided ranged from £1,000 to £62,000 per annum for training and £1,244 to £10,000 for travel. These training and travel budgets showed no relationship to the number of determinations carried out in a PCT, or to the number of RNs undertaking determinations (for the training budgets).

Determination of new residents costs

From the study data, the percentage of new residents as a proportion of existing residents indicated that the median value was 21% (range 3% to 93%). Therefore, using 21% of the data on number of self funding and LA residents above, there are approximately 27,355 new residents requiring determination annually. As new residents should receive a three months review of the original determination, an estimate of the total number of determinations carried out on new residents is approximately 54,710 determinations.

Using the same method as above, the annual cost of determinations for new residents are therefore estimated to be approximately £1 million (£820,650).

Total cost of time spent on RNCC annually

The total, annual costs of determination of new residents and re-determination of existing residents is estimated to be approximately £3 million per annum. This estimated cost refers only to direct time spent on determination. The annual cost of indirect time spent on determinations, derived from the information at PCT level, indicates that the indirect costs of staff time spent on RNCC is twice that spent on the determination itself. The total cost of RNCC, direct and indirect time is therefore estimated to be approximately £9 million per annum.

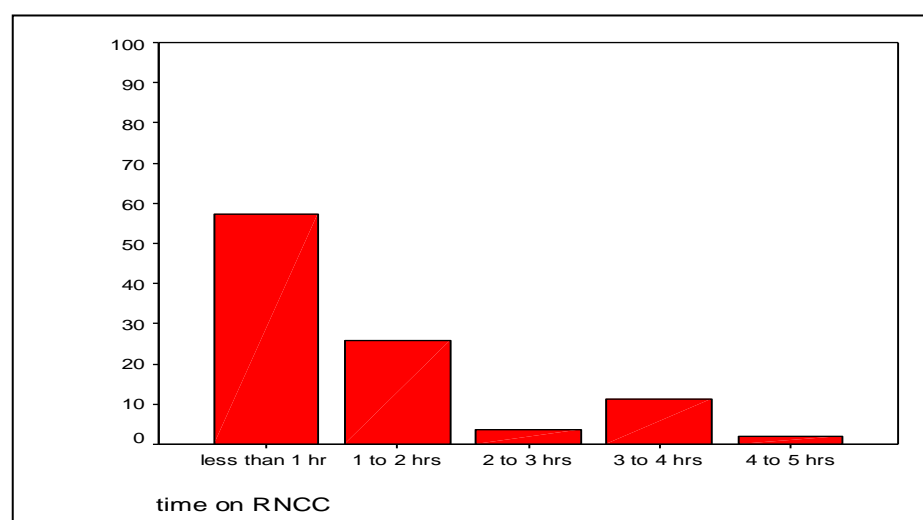
3.3.5 Care home resources required to support RNCC determinations

Care home resources required to support RNCC determinations. The main findings were:

- On average, approximately one in three care homes reported that their staff spent a median of 1 hour in support of each determinations; of these some two-thirds said that staff time was also spent on monitoring outcomes of determinations in the home. More time was spent by staff in smaller care homes.
- Costs to the independent sector are estimated to be approximately £2.9 million annually. Interviews with stakeholders in stage 1 identified that the large nursing chains could achieve certain economies of scale, but for individual, independent care homes this would not be possible.
- Just under two thirds of care homes' respondents reported that the time required was acceptable, but over a third (37%) stated that more frequent determinations would have major implications for care home staff resources.

In general, as might be expected, the time that care homes reported their staff spent on preparing for, and supporting the conduct of, determinations was less than that reported by RNs (see Figure 3.22). Responses to the stage 1 survey (questionnaire C), showed that just over one third of care homes (37%) reported that, on average, their staff spent 1 hour in support of each determination; of these, 67% said that staff time was also spent on monitoring outcomes of determinations in the home.

Figure 3.22*: Estimated time spent per RNCC determination by care homes



* Stage 1 survey (questionnaire C)

In terms of the impact of size of home, the only pattern observed is one of relatively more time being spent by staff in smaller care homes. It is unclear why this should be the case, although there may be economies of scale in larger care homes. Only four care homes (5%) reported that they had an identified budget for RNCC determination; one large chain home and three small independent homes. These homes did not report spending any more or less time on determinations than other care homes.

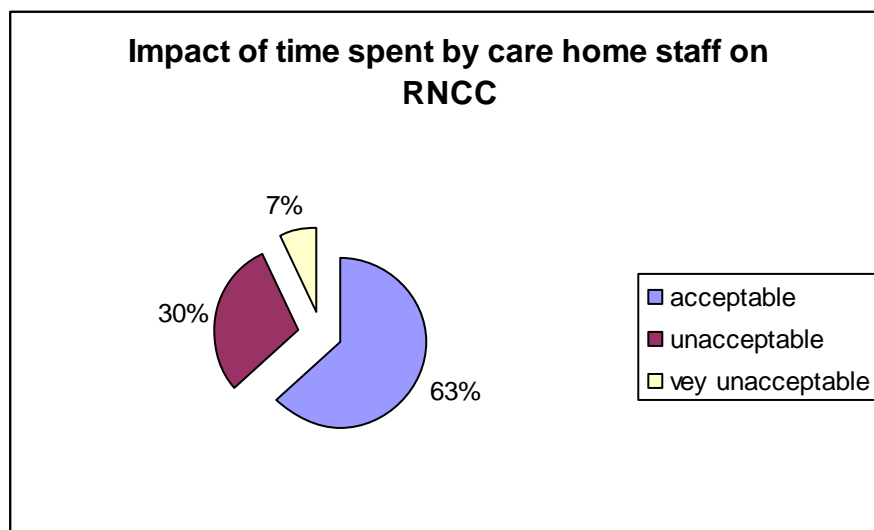
Once again, indirect costs will be incurred in the independent care home sector by managers who monitor RNCC payments and nurses who participate in banding discussions. Information from care homes (questionnaire C) indicated that on average at least one hour was spent per determination in 57% of care homes, while 27% spent between one and two hours per determination. The remainder spent between 3 and four hours per resident. Using the same G grade pay scale as for PCT staff (see section 3.3.4), the time spent by independent sector staff (an average 1.5 hours per determination) and the total number of determinations undertaken in England in 2002 on 130,264 residents (Figure from DoH web site: NHS FNC December 2002 census of residents of care homes receiving nursing care in England)), the costs to the independent sector are estimated to be approximately £7.4 million annually. Interviews with stakeholders in stage 1 identified that the large nursing chains could achieve certain economies of scale, but for individual, independent care homes this would not be possible.

"We have nursing homes all over the country and all areas have different methods. We have had to employ 3 extra staff to administer the system at the centre, and in all there are 10 staff involved in receiving, recording and refunding monies" {stage 1 care home interviewee}.

Care homes were also asked whether the amount of time involved for care home staff was acceptable (stage 2 survey, questionnaire CC). Figure 3.23 shows that just under two thirds of respondents reported that the time required was acceptable. However, a third of care homes (37%) reported that it was either unacceptable or very unacceptable. The number of residents in this third of homes ranged from 22 to 133 (median 38), very similar to those for all homes (range 20 to 133 median 39.5).

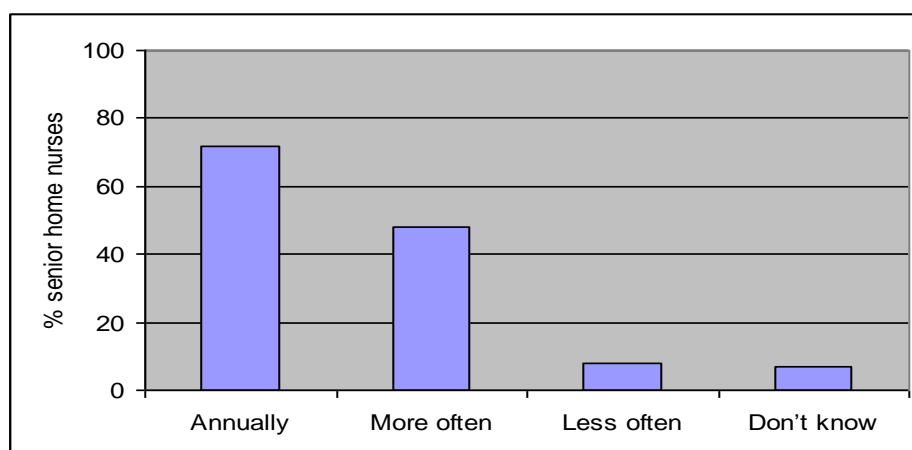
Similarly, approximately one third (29%) of respondents in care homes (questionnaire CC) thought that annual determinations were acceptable, as shown in Figure 3.24. However, over a third (37%) stated that more frequent determinations would have major implications for care home staff resources.

Figure 3.23*: Acceptability to care homes of time spent on RNCC determinations



* Stage 2 survey (questionnaire CC)

Figure 3.24*: care home views on acceptability of annual RNCC determination



* Stage 1 survey (questionnaire C)

3.4 RNCC DETERMINATION PROCESS

3.4.1 Participants involved in RNCC determination process

Participants involved in RNCC determination process. The main findings are:

- A majority of PCT nurses indicated that potential residents in hospital and in their own home and relatives were involved in the determination process, but the involvement of care home staff was less likely for these new admissions.
- A liaison nurse or a community nurse were each identified as being involved in the RNCC process for new self-funding admissions from hospital or own home respectively, but social services and medical staff had a low level of involvement. The pattern for new admissions who were LA funded was similar.
- Based on their experience of (primarily) existing residents, over half of the care homes staff reported that they were always involved with the RNCC determinations which had been conducted in their homes.

(i) PCT staff perspective on people involved in RNCC determinations

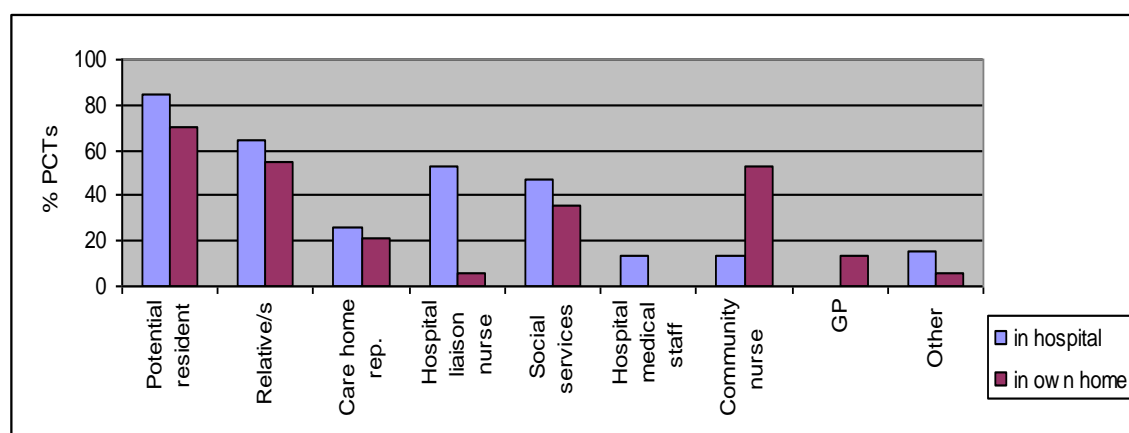
In the stage 2 survey (questionnaire AB), PCT co-ordinators/ lead nurses/ RNs were asked which staff participated in the determination process for new residents admitted from either hospital or own home. They were asked separately about self-funding residents and local authority supported residents, and also asked to distinguish admissions from a person's own home versus those from hospital. The results are shown in Figures 3.25 and 3.26.

For new self-funded residents, Figure 3.25 shows that most PCTs' nurses reported that the resident would be involved in the determination, with slightly fewer if it was an admission from home (ca 70% vs 85%). A significant percentage of PCTs also reported that relatives would be involved, once again slightly more for admissions from hospital (ca 64% v 51%). A care home representative (nurse or manager) was unlikely to be involved if the resident was either in hospital or in own home, as this was reported to be the case in only 20% - 25% of PCTs.

In terms of nursing staff for potential new residents to be admitted from hospital, a hospital liaison nurse was most likely to be involved, and for potential admissions from their own home, this was likely to be a community nurse. Social Services staff were slightly more likely to be involved with potential admissions from hospital than those being admitted from their own home, but the level of involvement was low for both.

Finally, it was rarely specified that medical staff participated (ca 15% of PCTs); GPs for admissions from home and hospital (17%); medical staff for new residents being admitted from hospital (4%) A few PCTs mentioned other participants such as advocates from Age Concern, joint care teams, continuing care nurses etc.

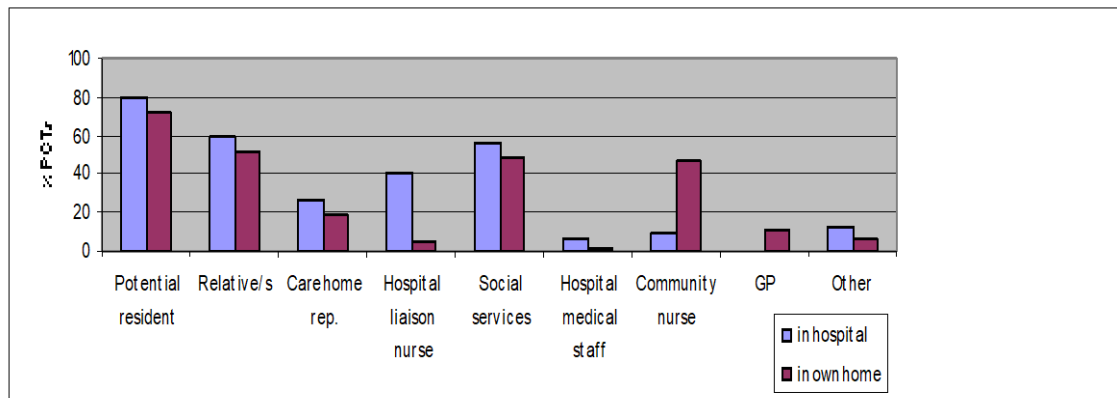
Figure 3.25*: Participants in determinations for new self-funding resident admissions



* Stage 2 survey (questionnaire AB)

Thus, the patterns reported by PCT nurses indicate a complex process with a number of different professional groups as well as residents and their relatives involved in the determination process for self-funded potential residents. For LA-funded residents, a similar pattern is reported as shown in Figure 3.26.

Figure 3.26*: Participants in determinations for new LA-supported resident admissions

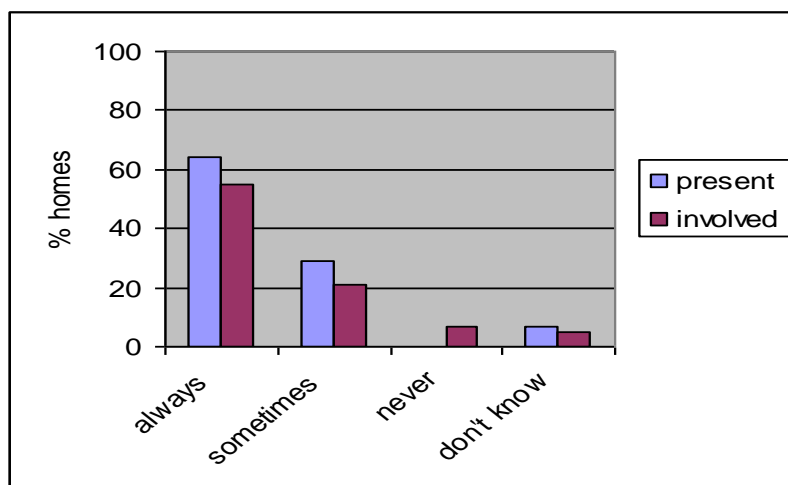


* Stage 2 survey (questionnaire AB)

(ii) Care home staff perspective on people involved in RNCC determinations

Care homes were asked in the stage 2 survey (questionnaire CC) whether they were usually or always present during determinations, and whether they were involved in the determination process (see Figure 3.27). Results indicate that only a small percentage of care homes reported that their staff were never involved; none reported that they were never present. Over half of care homes reported that they were always involved in determinations with nearly two thirds saying they were always present. Although this suggests a more favourable picture than that reported above by co-ordinators/ lead nurses, in this case care homes' staff were most likely responding with a different population in mind, i.e. existing self-funding residents and any new residents post admission.

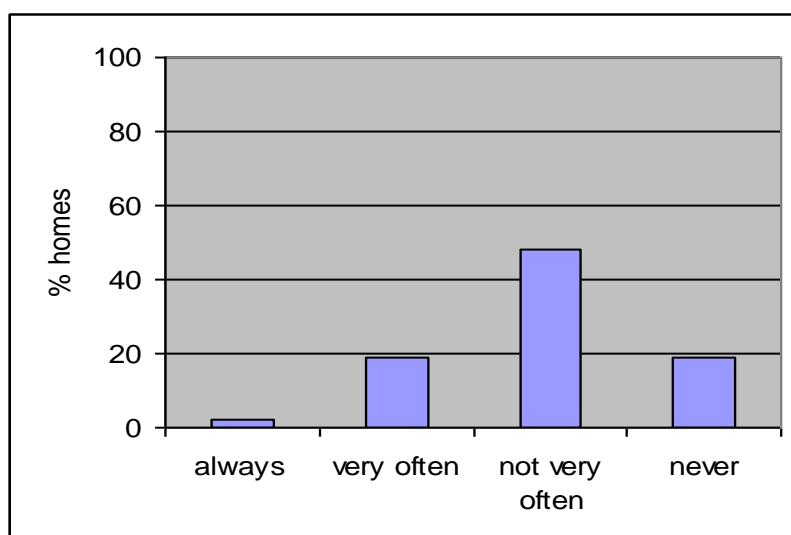
Figure 3.27*: Care home staff involvement in determinations



* Stage 2 survey (questionnaire CC)

Care homes were similarly asked in the stage 2 survey (questionnaire CC) about the frequency of involvement of relatives in the determination process. Only one fifth of care home managers (21%) reported that relatives were always or very often involved, with 67% reporting that relatives were never or not very often involved (see Figure 3.28). This contrasts with the involvement of relatives, as reported by PCT nurses (questionnaire AB) in Figures 3.25 and 3.26, where between 51% and 64% of PCTs indicated that relatives are involved in determinations for new admissions. Once again, the same caution applies as above. It may also be that relatives are more likely to be involved in any process that may influence decision making on admission to a care home. Choice of a particular home by self-funders may well be influenced by additional payments from FNC after determination outcome.

Figure 3.28*: Relatives involvement in determinations



* Stage 2 survey (questionnaire CC)

3.4.2 Sources of information used for RNCC banding and access to results

Sources of information used for RNCC banding and access to results. The main findings were:

- Almost three-quarters of co-ordinators/ lead nurses in stage 1 reported that the determination was always conducted using care home documentation plus a meeting with the resident. A majority of the remainder sometimes used documentation alone, but a few reported that they always used documentation alone. This picture was similarly confirmed by care homes' senior nursing staff responses in the stage 1 survey.
- Stage 2 responses from care home staff indicate that fewer than half of the residents (45%) and relatives (41%) are informed of outcome at the time of the determination. One third of care homes' staff reported that their residents were informed in writing, and one fifth that it was verbal information; while the remainder did not respond to this question. Relatives were slightly more likely to be informed in writing than residents.
- RNs were those most likely to have access to determination records, with almost two-thirds of PCTs indicated that they do. Whereas only half of PCTs reported that residents and care home managers have access.

(i) Use of care home documentation in RNCC determination

In the stage 1 stakeholder interviews, an important point raised was that care plans should reflect a resident's RN needs, otherwise reliance upon information given in the plans during determination may lead to inappropriate banding decision, as illustrated by the following comment:

“Role [*of RN*] is to determine level of RN input required. Care Plans written by care home staff after assessments should reflect RN input. If Care Plans do not work, the question is, is it the assessment or does it reflect patient need?” {stage 1 care home interviewee}.

However, there was a view expressed that if care plans were accurate, documentation alone might be sufficient for an accurate determination in most cases:

“Care plan offers definite banding choice. If [*resident is*] borderline or uncertainty, resident is assessed also” {stage 1 PCT interviewee}.

The information on which determinations are based was therefore examined further in the surveys. In the stage 1 survey (questionnaire A), 72% of co-ordinators/ lead nurses reported that decisions on RNCC banding are *always* made on care home documentation evidence *plus* a meeting with the resident; and only 3% reported that decisions were always made on documentation evidence *only*. The use of documentation alone did not depend on the number of determinations undertaken in a PCT. A further 17% reported that decisions were *sometimes* made on documentation evidence only. The main reason for using documentation evidence only (and not involving the resident) was reported to be lack of time. Other reasons included: where resident was deceased (8%); in respite care or had gone home (9%); only if resident is borderline on banding or documentation unclear (4%); local/ HA direction to use documentation only (3%); if resident is in a confused mental state (2%).

Care home senior nurses were similarly asked in the stage 1 survey (questionnaire C) how documentation evidence was use in making RNCC banding decisions for their residents. Over two thirds of respondents (68%) reported that banding decisions in their care home were always made on documentation evidence *plus* the RN meeting with the resident; this compared well with 72% of co-ordinators/ lead nurses who reported the same (questionnaire A). Very few care homes (3%) reported that decisions were being made on documentation evidence only (identical to the 3% reported by PCTs), and once again the main reason given was lack of time.

(ii) Information on RNCC determination outcome for residents and relatives

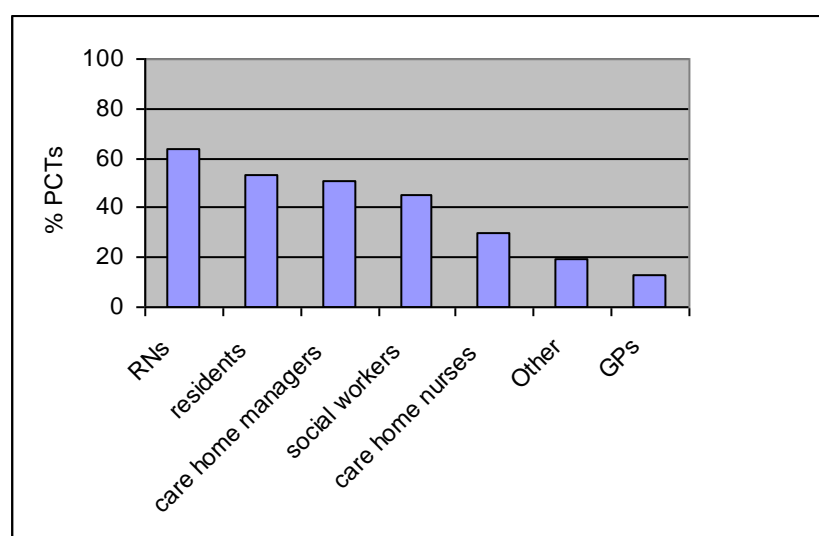
Care home staff were asked how and when residents and their relatives are informed of the outcome of the determination. Responses to the stage 2 survey (questionnaire CC) indicate that fewer than half of care homes' residents (45%) and relatives (41%) are informed at the time of the determination. Where residents are informed, one third of care homes (31%) report that this is in writing, and one fifth (21%)

that it is verbal information; the remaining 48% did not respond to this question. Relatives were slightly more likely to be informed in writing (41% of care homes), with just over one third (38%) receiving verbal information, while the other 21% of care homes did not respond.

(iii) Access to RNCC determination records

Responses to the stage 2 survey (questionnaire AB) indicated that the people most likely to have access to determination records are RNs, who have access in 64% of PCTs, as shown in Figure 3.29. Only half of PCTs reported that residents and care home managers have access (51%). One respondent said that access to the determination records was only via the co-ordinator on a 'need to know basis'. Other people reported to have access included social workers, care home nurses, GPs and 'others' such as joint care teams and relatives.

Figure 3.29*: Access to determination records



* Stage 2 survey (questionnaire AB)

3.4.3 Quality assurance and RNCC banding

Quality assurance and RNCC banding. The main findings were:

- Almost three-fifths of PCT co-ordinators/ lead nurses reported in stage 1 that the main quality assurance method comprised spot checks of RN bandings, often in combination with monthly audit using the DoH audit tool.
- In the stage 2 survey, most PCT nurses (68%) reported that they liaised with other PCTs regarding quality assurance for RNCC bandings.
- Approximately one quarter of PCTs included members of the independent sector in the quality assurance process.
- Responses to the stage 1 care homes' survey indicated that some two thirds of senior nursing staff in care homes either did not know how NHS quality assurance of determinations was managed or thought that it was not undertaken at all.

Co-ordinators/lead nurses indicated in their responses to the stage 1 survey (questionnaire A) that quality assurance is mainly accomplished by spot checks of RN bandings (56% of PCTs), often in combination with monthly audit using the DoH audit tool (34%). ‘Other’ methods reported by 28% of PCTs included use of the PCT’s own audit tool, peer review, or monthly audit of a sample of determination records and different methods were often used in combination.

In response to the stage 2 survey (questionnaire AB) all PCT co-ordinators (100%), most lead nurses (90%) and co-ordinator/ lead nurses (92%) reported that they liaised with other PCTs regarding quality assurance for RNCC bandings. Such liaison was usually regular (64%) and formal (74%). Approximately one quarter of PCTs (26%) reported that members of the independent sector were also involved in the process. These were usually representatives of nursing care home groups or panels.

Care home staff generally had little awareness of quality assurance of RNCC determinations. Responses to the stage 1 survey (questionnaire C) indicated that some two thirds of senior nursing staff in care homes (63%) either did not know how NHS quality assurance of determinations was managed or thought that it was not undertaken at all. Fewer than one third of care homes (27%) identified routine review of RN documentation as a means of quality assurance in their locality, and fewer than 5% knew of spot checks on RN bandings in their PCT. The least likely group of care home managers to identify spot checks were managers of independently owned homes (none) although routine review was identified.

3.4.4 Processes for appeal and informal review

Processes for appeal and informal review. The main findings were:

- Some three-fifths of stage 2 PCT nurses reported that their PCTs had formal appeals bodies/ committees, with a further small number noting that SHAs were beginning to set up appeals processes.
- In one in ten of the PCTs, the original RN would be present during an appeal.
- In most PCTs, the co-ordinator or lead nurse is responsible for disseminating appeal outcomes.
- All PCTs with experience of appeals stated that the appeal outcome would be disseminated to residents and relative(s), and to care home managers in 62% of PCTs.
- The responsibility for re-determination following an appeal was reported to lie with the co-ordinator/ lead nurse in two-fifths of PCTs (stage 1 survey), and in one third of PCTs re-determinations are undertaken by a nurse from another PCT.
- Fewer than 10% of PCTs indicated that following appeal, re-training of the person conducting determination was sometimes undertaken, and a quarter of PCTs stated that there was no system for re-training.

(i) Staff involved in appeals

In the stage 2 survey (questionnaire AB), 57% of co-ordinators/ lead nurses/ RNs reported that their PCT has a formal appeals body/ committee which usually involves the co-ordinator/ lead nurse, resident, relatives, local panels (e.g. continuing care panel), and members of a neighbouring PCT. A small number (6%) noted that SHAs were now becoming involved in the setting up of appeals

processes. One respondent commented that, if there was no agreed resolution, then an appeal might go to a complaints panel. Just under one half (49%) stated that appeals procedures are documented.

One third of PCTs (34%) reported that the original RN carrying out the determination was not present at any stage of the appeals process in their response to the stage 1 survey (questionnaire A). The original RN would be present during an appeal in one in ten PCTs (12%).

Relatively few care homes (17%) reported that their staff were involved in the appeals process, and 12% said that they were definitely not involved. The remainder did not know or did not answer the question. However, as relatively few appeals have taken place, it is likely that most of the care homes will not have had any experience of appeals.

(ii) Output from appeals and informal reviews

Once the appeal process is complete, responses to the stage 2 survey (questionnaire AB), indicate that the responsibility for disseminating appeal outcomes lies centrally with co-ordinators or lead nurses in 55% of PCTs (21% did not respond). Other identified persons with responsibility included chairpersons of the continuing care panel, for example. RNs undertaking determinations reported that they were not involved in appeals (questionnaire B).

All PCTs who responded to our surveys (except one with no experience of appeals) reported that the result of an appeal would be given to both residents and their relatives (questionnaire AB). Results were not dissemination to care homes in just over one third of PCTs. Thus, although there is consistency in the routes adopted in so far as residents and relatives are concerned, there is less consistency in terms of whether care homes are informed. The responsibility for dissemination lies principally with the co-ordinator or lead nurse.

The responsibility for any re-determination required following an appeal is reported to lie with the co-ordinator/ lead nurse in 40% of PCTs (stage 1 survey, questionnaire A). In one third of PCTs (34%) re-determinations are undertaken by a nurse from another PCT. PCTs also mentioned other professionals involved in re-determination including another district nurse or a community liaison nurse. If the appeal is not resolved locally, it might be passed to a continuing care panel in a different PCT for re-determination with an appeals leaflet for resident/ relatives.

Only a small percentage (15%) of co-ordinators/lead nurses reported that systems were in place for re-training RNs following a successful appeal (stage 1 survey, questionnaire A). A further 8% of PCTs indicated that re-training was sometimes undertaken. But a quarter of PCTs (25%) stated that there was no system for re-training RNs after appeals.

3.4.5 Views on RNCC tool and determination process

Views on RNCC tool and determination process. Main findings were:

- PCT and care home stakeholders interviewed in stage 1 did not provide a consistent view on the RNCC tool and raised questions about its appropriateness for residents with a mental health condition.
- Care home staff also rated the ability of the tool to achieve the correct banding as high. Furthermore, perceived levels of agreement by residents/ relatives with the banding were also rated as high.
- Co-ordinator/ lead nurse responses in the stage 1 survey indicated positive ratings for use of the RNCC tool in terms of confidence and achievement of correct banding; levels of agreement by residents/ relatives with bandings; and banding agreement by care home staff. Stage 1 RN respondents demonstrated a high level of confidence in the tool on the same three dimensions, although there was more disquiet over its ability to achieve correct banding in this group of staff.
- Senior nursing staff in care homes identified the need for more information about the RNCC determination tool, and resources to cover input into determinations by care home staff as the most important issues in their facilitation of the RNCC process.
- Some one third of RNs surveyed in stage 1 indicated the need for changes to the RNCC tool, and half felt that the process of determination was challenged by either a lack of time, or a lack of manpower.
- Forty-six percent of stage 1 co-ordinators/ lead nurses reported that they had made adaptations to the RNCC tool documentation, most frequently reported as alterations to the front sheet. However, one in ten of them reported the inclusion of an assessment sheet. A quarter of RNs (25%) reported that changes had been made to the RNCC tool, agreed by the PCT. Changes had been suggested by co-ordinators (14%), lead nurses (18%) and RNs (17%) often in combination. RNs agreed (73%) with an annual determination time scale.
- Lead PCT nurses in stage 2 reported that they were responsible for maintenance of determination records and whereas some two thirds indicated that their PCT uses a combination of paper and electronic systems for determination records, almost one quarter use a paper only system.

(i) Views of stakeholders on RNCC tool and determination process

In stage 1 interviews, it was consistently reported by regional and SHA stakeholders that the RNCC tool appeared to be a useful measure for determining nursing needs of care home residents when used in conjunction with a resident's care plan and discussion with care home staff. However, these stakeholders pointed out that nurse users would be best placed to confirm this impression. In fact, PCT and care home stakeholders interviewed in stage 1 did not provide a consistent view on the tool and, in some cases, there was only a pragmatic acceptance of it:

"Our staff are happy with the RNCC tool plus professional judgement" {stage 1 PCT interviewee}.

"The RNCC is an acceptable tool and no changes are needed" {stage 1 PCT interviewee}.

"The tool depends on the person using it. It is not a research based tool" {stage 1 PCT interviewee}}.

"No confidence at all" {stage 1 PCT interviewee}.

"Not confident [*about tool*]. Residents are assessed prior to RNCC tool determination and our care home staff record a higher [*level*] than the high RNCC outcome (some have very complicated feeding regimes). Our nursing staff know the residents well and we have a good, well established model of care for assessing their dependencies. It is often difficult to achieve an agreed outcome and this causes problems" {stage 1 care home interviewee}.

"It is as good as available with the time constraints" {stage 1 PCT interviewee}.

However, both PCT nurses and care home interviewees raised questions about the appropriateness of the tool for residents with a mental health condition.

"RNCC tool does not work for EMI residents" {stage 1 PCT interviewee}.

"On determination our EMI residents were placed in a low banding where it was apparent that they required a high level of nursing care" {stage 1 care home interviewee}.

Several PCTs reported that they were in the process of amending the RNCC tool, in some cases combining its use with that of an assessment tool.

"Nursing staff always assess residents using one of the activities of daily living (ADL) assessments tools prior to determination and discussion with care home managers" {stage 1 PCT interviewee}.

"We use our own ADL assessment as well as the RNCC tool" {stage 1 PCT interviewee}.

"It [*RNCC tool*] is a useful exercise. It is no use on its own. We were advised to assess first" {stage 1 PCT interviewee}.

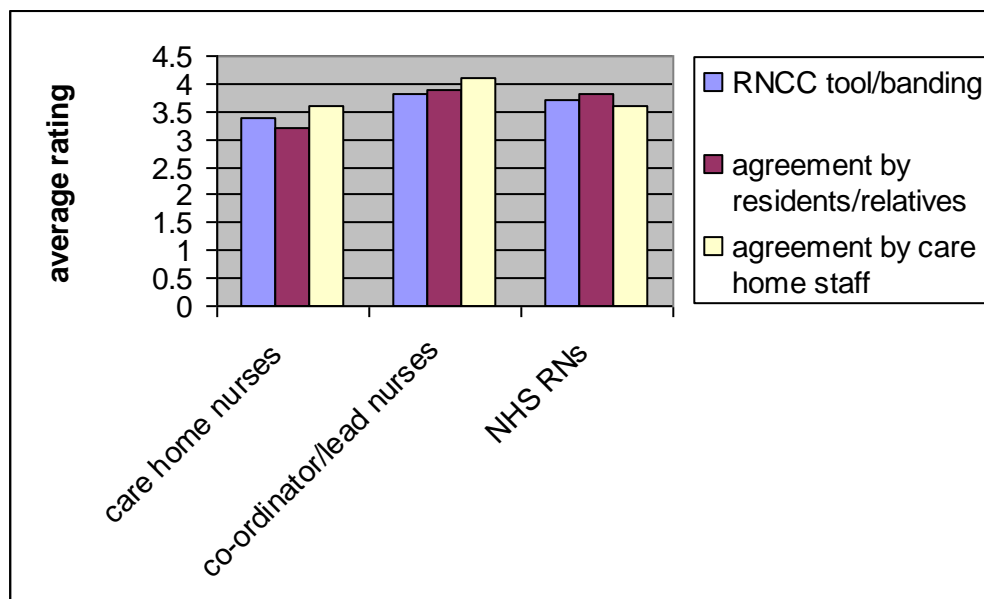
"RNCC tool ... we use ADL assessment, our own adaptation, and follow with RNCC (it was fairly straight forward with those who had already been assessed) {stage 1 PCT interviewee}.

(ii) Confidence of PCT and care home staff in RNCC tool

A quarter of RNs (25%) reported that changes had been made to the RNCC tool and agreed by the PCT. Changes had been suggested by co-ordinators (14%), lead nurses (18%) and RNs (17%) often in combination. RNs agreed (73%) with an annual determination time scale

Regardless of the way in which the tool is applied, care home staff, NHS co-ordinators/ lead nurses and RNs undertaking determinations all rated the ability of the tool to achieve the correct banding positively, with average scores of 3.4 on a 1 to 5 scale, where 1 is 'very low' and 5 is 'very high' (see Figure 3.30). Furthermore, the perceived level of agreement by residents/relatives with the banding (3.8), and agreement by care home staff (3.6) were also rated high by all three staff groups.

Figure 3.30*: Average ratings on RNCC tool and bandings by all professional groups

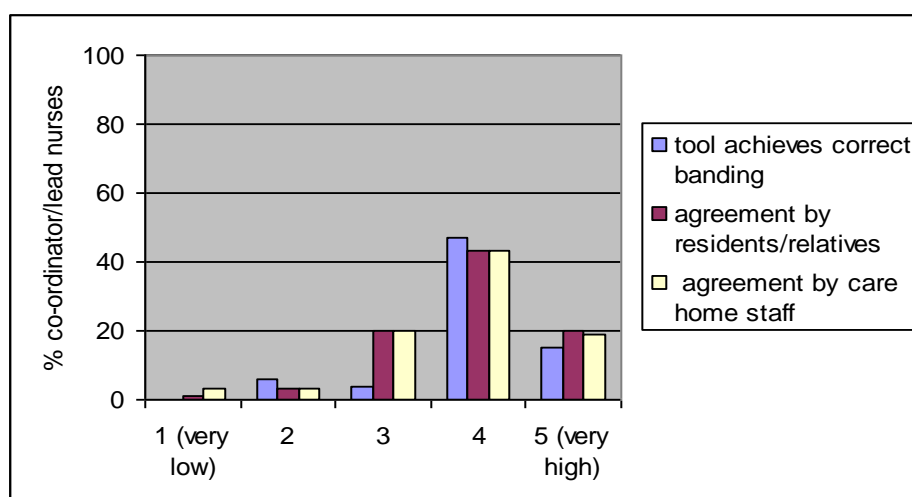


* Care home nurses (questionnaire C) * Co-ordinators/ lead nurses (questionnaire A)

* NHS RNs (questionnaire B)

The actual spread of ratings for co-ordinator/ lead nurse responses to the stage 1 survey (questionnaire A) is shown in Figure 3.31. These results indicate very little evidence (<6% of respondents) of very low or low confidence in the RNCC tool. The average rating for the RNCC tool to achieve correct banding is 3.8; perceived levels of agreement by residents/relatives with bandings is 3.9; and banding agreement by care home staff is 4.1. There was no statistically significant between rating on the RNCC tool to achieve correct banding and 'experience' or the number of determinations carried out in a PCT.

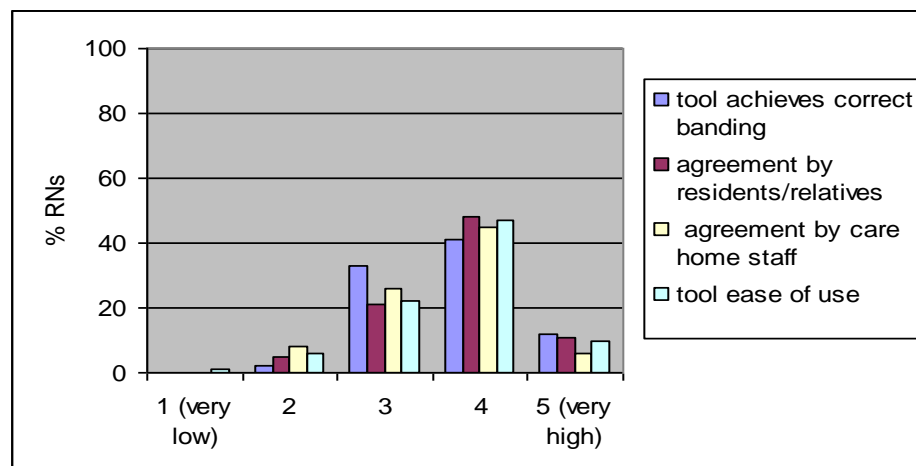
Figure 3.31*: Co-ordinator/ lead nurse confidence in RNCC tool



* Stage 1 survey (questionnaire A)

Similarly, RN respondents (questionnaire B) also demonstrated a high level of confidence in the tool on the same three dimensions, as shown in Figure 3.32. Once again, <8% of respondents report low or very low confidence in the RNCC tool, although there appears to be slightly more disquiet over its ability to achieve correct banding in this group of staff. The average RN ratings are as follows: for the RNCC tool to achieve correct banding 3.7; banding agreement by residents/relatives 3.8; and banding agreement by care home staff 3.6. This group were also asked about the ease of use of the RNCC tool. This was similarly rated positively at 3.7.

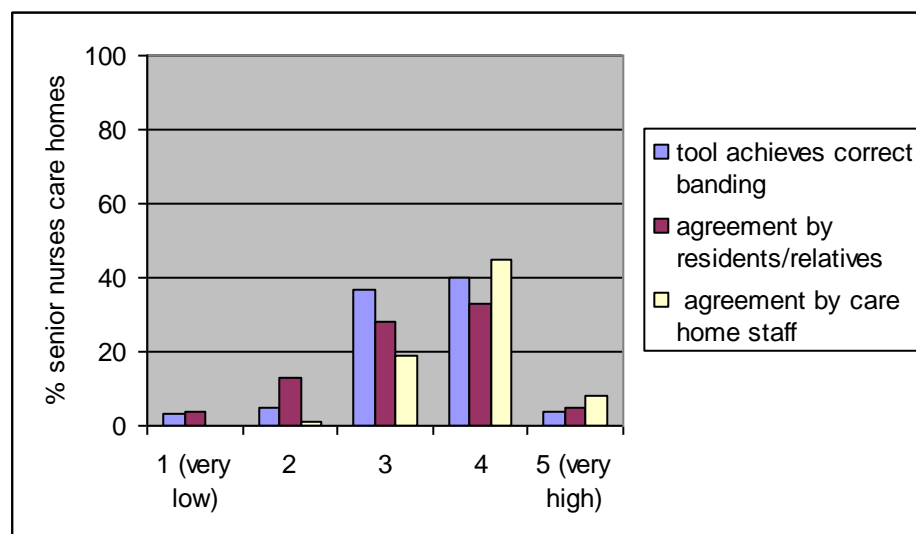
Figure 3.32*: RN confidence in RNCC tool



* Stage 1 survey (questionnaire B)

When care home staff were asked the same questions Figure 3.33 shows that, once again, very few senior nurses in care homes (<5%) rated the RNCC tool as low or very low in terms of its ability to achieve the correct banding. The overall pattern was most similar to that reported by the RNs undertaking determinations.

Figure 3.33*: Care home staff confidence in RNCC tool

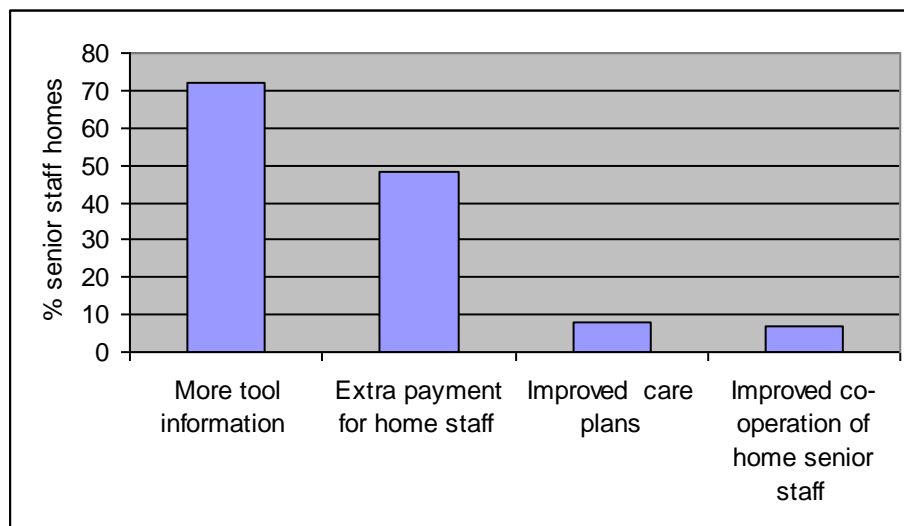


* Stage 1 survey (questionnaire C)

(iii) Changes to facilitate RNCC determinations in care homes

By far the most important change identified by senior nursing staff in care homes as facilitating the determination process would be provision of more information about the RNCC determination tool, as shown in Figure 3.34. The next most important factor would be provision of resources to cover input into determinations by care home staff.

Figure 3.34*: Care home staff views on facilitation of RNCC determination process**



* Stage 2 survey (questionnaire CC)

** More than 1 category of reply

Even in three out of the four care homes that had an identified budget for RNCC determination, senior nursing staff identified extra payment for care home nursing staff time required to support determination as important in facilitating the process. Other changes such as improved care plans or improved co-operation of senior care home staff were considered far less important.

(iv) Additions to RNCC tool/ determination process

Nursing staff were asked about adaptations to the RNCC tool. In the stage 1 survey of RNs (questionnaire B), 37 (36%) of the 102 respondents provided qualitative comments indicating that changes had or should be made to the RNCC tool in order to improve the decision-making for banding. Of these, 13 (35%) suggested incorporating an additional form of assessment and/ or the use of a scoring system to the RNCC tool. The following comments indicate that some RNs perceived the process of decision-making in determining an appropriate band as requiring a more general assessment than the use of the RNCC tool alone could achieve:

“We have made changes – increased the number of domains, amount of information collected and are developing as scoring system” {free text comment questionnaire B}.

“An additional information sheet has proved very important to document patients’ history and nursing care received in reaching a decision for banding” {free text comment questionnaire B}.

“We use a nursing model to help determine nursing needs and then transfer them onto RNCC form” {free text comment questionnaire B}.

“Assessment is also carried out using ADL [*Activities for Daily Living*]” {free text comment questionnaire B}.

A further one third (N=12) suggested several areas of challenge in using the banding system. These included: problems of attaining consistency; the lack of structural guidance in determining the ‘best fit’ related to banding for individual patients, with a means of differentiating continuing care needs from those of relevance to the bandings; and improvement to care home documentation.

“An agreed framework to help with the banding of patients to ensure consistency of determinations...” {free text comment questionnaire B}.

“Clearer banding criteria which incorporates continuing care criteria. I do not think this is applied as it should be, due to lack of knowledge” {free text comment questionnaire B}.

“Nursing home staff to improve quality of care planning documentation in order to ease process of determinations” {free text comment questionnaire B}.

RNs carrying out determinations were asked if there were other issues or challenges for them. Of the 67 (67%) RNs who responded, 33 (49%) raised increased pressure on either time or manpower caused by FNC, and their relationship with a perceived lack of supportive resource:

“Time is a major factor. All determinations have to be fitted into ordinary day’s work which for a district nurse is never predictable. Education of NH [Nursing home] staff in RNCC and what is required in patient notes to assist in determination process {free text comment questionnaire B}.

“Time commitment – revisions will be needed to be done on self-funders at the same time that determinations will need to be done on SS clients in 2003” {free text comment questionnaire B}.

“Some facilities not getting the money intended to pay for registered nursing care. When do we stop absorbing additional work without the resources to go with it? {free text comment questionnaire B}.

Nursing staff were asked about adaptations to the RNCC tool. In the stage 1 survey (questionnaire A), 46% of co-ordinators/ lead nurses reported that they had made adaptations to the RNCC tool *documentation* in their PCT. Details of changes were provided with the questionnaires returned to the study team. These usually involved the collection of additional information at the same time as the determination, as opposed to changes in the actual determination tool itself. An overview of these is provided in Table 3.3.. Thirty three per cent of RNs reported that they had made adaptations to the RNCC tool, and 21% said there were other changes they would like to make. Overall, 29% of RNs reported that the determination system could be improved.

Most frequently reported adaptations were additions to the front sheet such as client/ assessor details plus additional information indicating whether it is an RNCC initial report, review, three monthly review, and whether local authority supported. Many reported the addition of the name of the social

worker, GP, OT, equipment needs, current resident location, current care provision, review date, and whether the determination was carried out retrospectively (post–death). RNs reported (questionnaire B) that these changes had been suggested by co-ordinators (14%), lead nurses (19%) and RNs (18%), usually in collaboration.

One in ten 11%) of co-ordinators/ lead nurses (questionnaire A) reported that an assessment sheet for the continuation of care placement was included, and also information on the continence assessment, care review or pressure relief information.

Very few PCTs (< 5%) included a consent form for the client. Even fewer included any rationale for the determination decision.

A few PCTs included one or more of the following:

- Care home application form for determination to be carried out
- Pathway for RNCC determination and reviews
- Delay of determination and reason for delay
- Joint health and social care assessment form
- Notification of RNCC contribution to District County Council
- Continence needs (yes/no checklist of products)
- Details standard services in care homes & specialist equipment
- Clinical needs assessment including standard equipment list
- RNCC “Assessment” form with 50 points to be allocated to bandings
- Appointment form for client
- First contact check list
- ‘Not banded’ category
- Mental health needs assessment
- Letters to client post determination
- Referral to continence advisor
- Standard equipment list
- Review document with Health Action Zone form

Only one in four (25%) of RNs said the changes introduced had been agreed by the PCT.

Table 3.3: PCTs with more than one addition to the RNCC tool

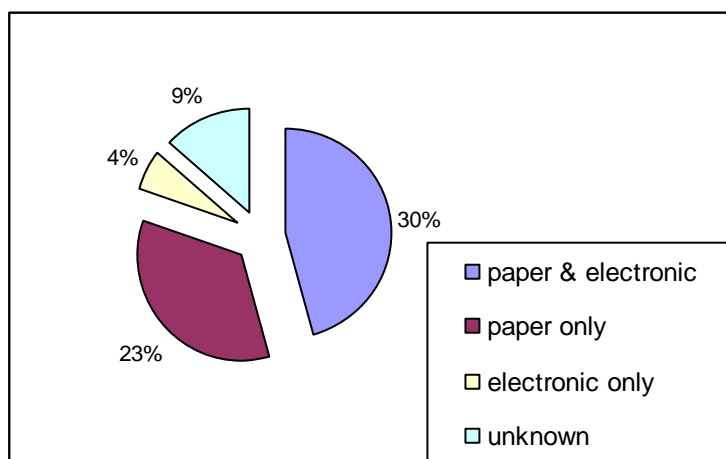
<i>PCT RE-CODED ID</i>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
ADDITIONS																							
Front sheet, Headings include: RNCC initial report, Review, 3 monthly review, LA funded NH assessment etc.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Consent form for client	✓	✓	✓																				
Appointment form for client	✓	✓	✓																				
Determination/review date	✓	✓	✓																				
Rationale for decision of determination							✓		✓														
'Not banded' category							✓	✓															
Continence needs, may include yes/no products							✓													✓	✓		
Assessment sheet continuum of care placement and may included continence assessment or review and pressure relief				✓	✓					✓						✓	✓	✓		✓	✓	✓	✓
Mental health needs assessment					✓								✓										

Of the total in Table above only two PCTs identified Mental Health assessment needs.

(v) RNCC determination record documentation

The majority of co-ordinators/lead nurses reported that they were responsible for maintenance of determination records (see section 3.2.3, ii). In the stage 2 survey (questionnaire AB), co-ordinators/lead nurses/ RNs were asked for details of the system used. Two thirds (64%) indicated that their PCT uses a combination of paper and electronic systems for determination records, although almost one quarter use paper only (see Figure 3.35). Very few (4%) are paperless (electronic only).

Figure 3.35*: NHS determination record types



* Stage 2 survey (questionnaire AB)

3.5 OUTCOMES OF RNCC DETERMINATIONS

This section considers the outcomes of determinations, including: eligibility of residents; perceived consistency of bandings; high, low and continuing care bands; and levels of appeals and informal reviews.

3.5.1 Eligibility for RNCC determination

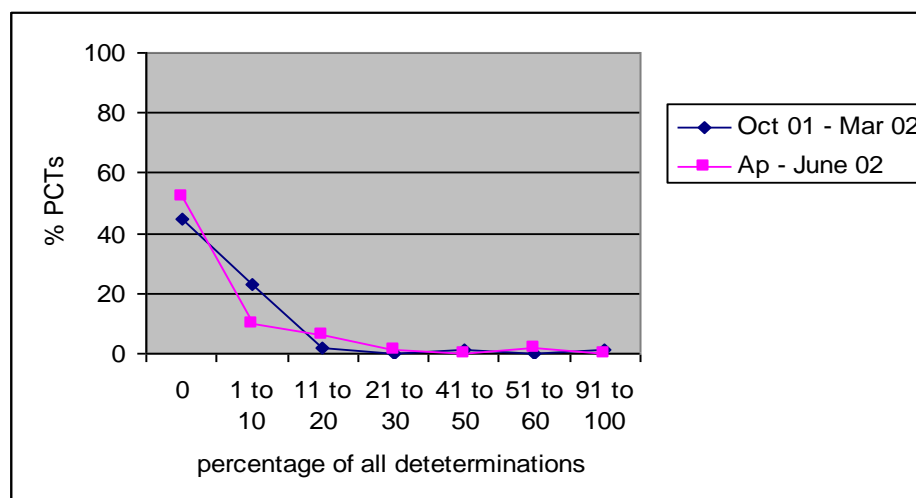
Eligibility for RNCC determination. The main findings were:

- Between October 1st 2001-March 31st 2002, up to 27% of existing residents were reported by co-ordinators/ lead nurses to be ineligible for determination. This reduced to a maximum of 3% of new residents identified as ineligible by PCT nurses between April 2002 and June 2002.

Co-ordinators/ lead nurses reported in the stage 1 survey (questionnaire A) that in the first round of determinations, between 1% and 27% of residents (maximum 132 individuals) in PCTs were found to be ineligible for funding indicating that there might be no need for RN care (see Figure 3.36). This situation improved with the next phase of determinations, carried out between April and June 2002, with between 1% and 3% (maximum 53 individuals) ineligible. Thus, the diagram shows that the percentage of PCTs reporting zero ineligible residents undergoing determinations rose from 45% in

the first 6 months to 53% in the following 3 months; at the same time, those with 1-10% of determinations judged to be ineligible fell from 22% to 9%. This trend may reflect better systems in place for notification of need for determination.

Figure 3.36*: PCTs reporting residents ineligible for RNCC funding



* Stage 1 survey (questionnaire A)

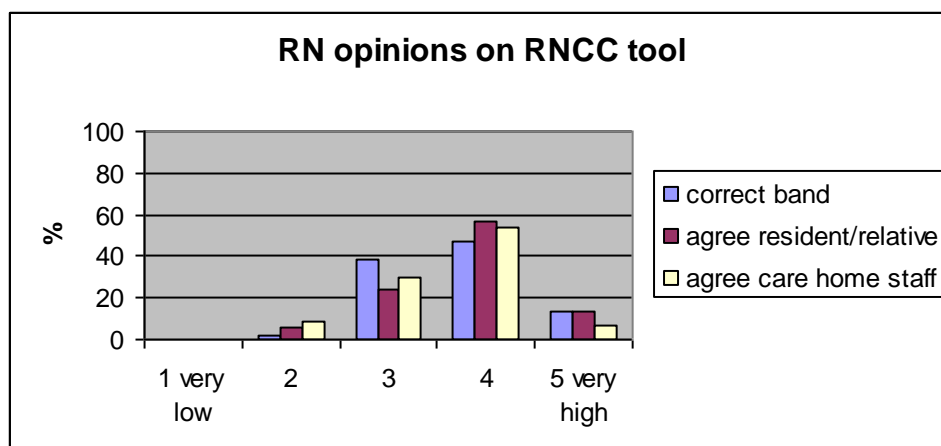
3.5.2 Consistency of RNCC banding

Consistency of RNCC banding. The main findings were:

- Both independent and public sector nurses indicated that there was no evidence of a lack of confidence in RNCC banding across the two stages of the study.
- A trend for new resident admissions to be given higher banding across the two FNC rounds was observed. Qualitative evidence supported a probable link to the changing 'mix' of patients as determinations moved from existing residents to new admissions, suggesting that RN nursing needs in the latter case might be greater if discharged from hospital.
- Of the one third of care home managers who agreed that a new resident improves after admission and would then fall into a lower banding, one quarter said that a re-determination was undertaken to ascertain change in the resident's health status, a fifth of them said that it took over a month for it to take place, and most said that it was at their request.

In response to the stage 1 survey (questionnaire A), 68% of co-ordinators/ lead nurses perceived that there was consistency of decision making across the banding range in their PCT, but the remainder either did not know or did not answer the question. Similarly in the stage 1 survey, RNs (questionnaire B) reported that the RNCC tool was rated high as a means of establishing a correct banding on a 1–5 scale (1=very low 5= very high), shown in Figure 3.37.

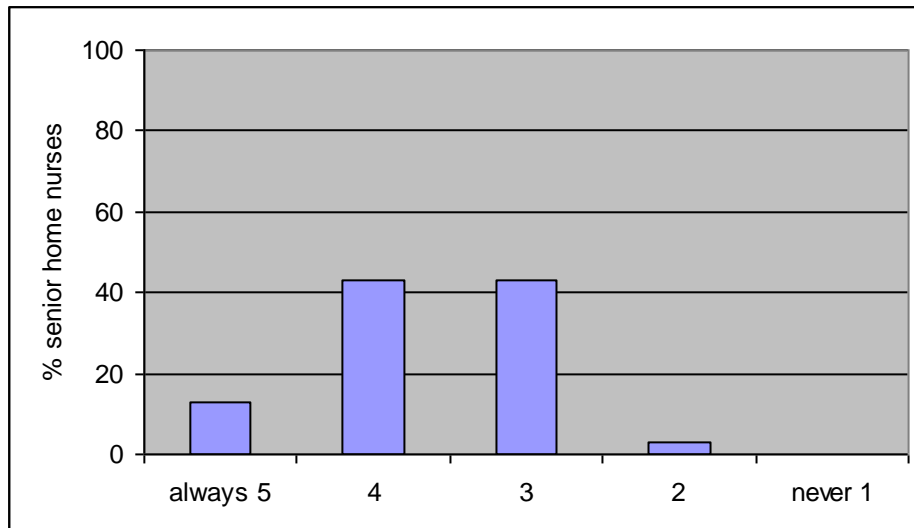
Figure 3.37*: RNs' opinions on ability of RNCC tool to achieve correct banding and resident/relative/ care home agreement with banding



*Stage 1 (questionnaire B)

Similarly, in response to the stage 2 survey (questionnaire CC), staff in care homes reported that the RNCC bandings usually matched their expectations, with an average rating of 3.7 (where 1= never 5= always), as shown in Figure 3.38. There was therefore no evidence of a lack of confidence in RNCC banding decisions.

Figure 3.38*: Care home staff opinion on whether banding matches expectations



* Stage 1 survey (questionnaire CC)

(i) High banding

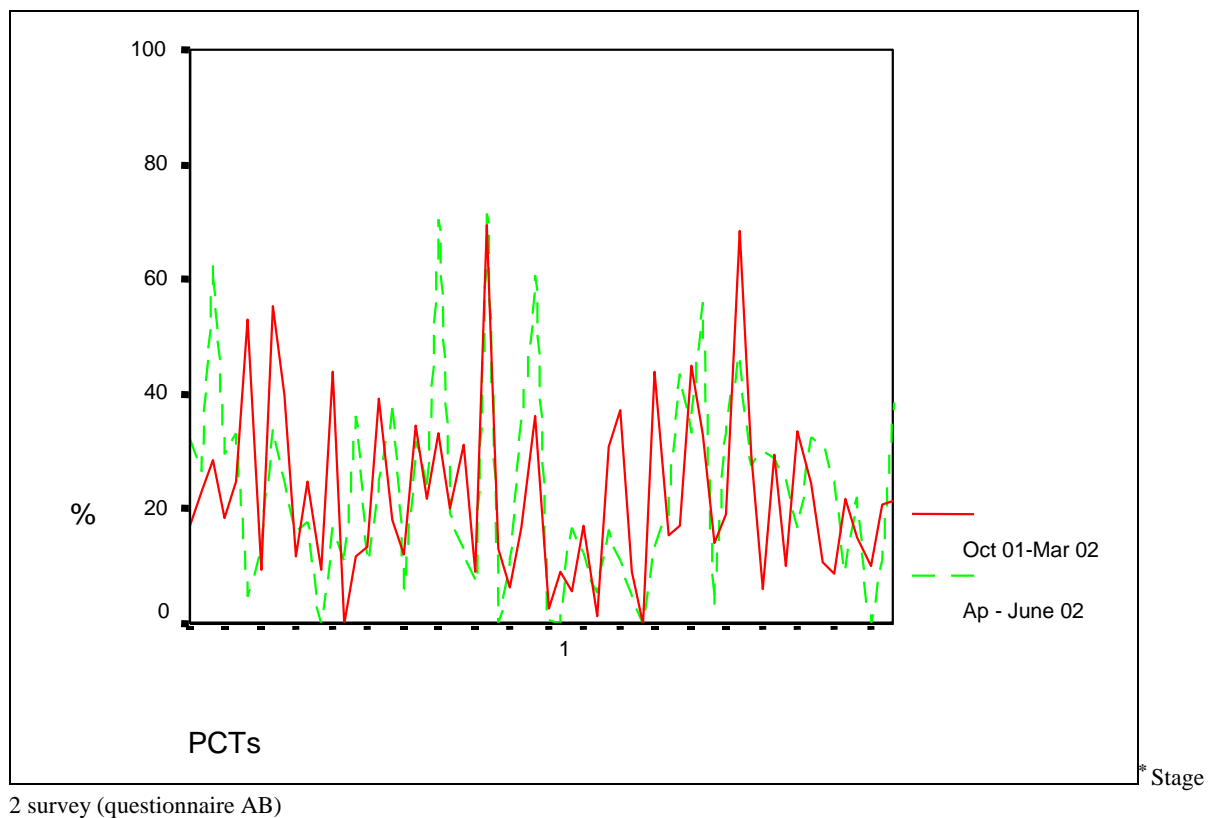
The percentage of high banded residents observed in a PCT was not stable over time. The top part of Figure 3.39 shows the percentage of self-funding residents banded high in a PCT based on determinations undertaken for existing residents (October 2001 - March 2002, solid line) compared with those banded high for new admissions (April - June 2002, dotted line). From this it appears that several PCTs demonstrated a notable increase in the percentage of residents falling into the high band, and a few showed a significant fall between the two time periods; with other PCTs remaining fairly constant over the two time periods.

The bottom part of Figure 3.39 compares the percentage of high banded residents in both time periods (October 2001 to March 2002 and April to June 2002) for individual PCTs. Those PCTs above the line had a higher percentage of high banded residents during the second time period (April to June 2002), and conversely for those below the line. This Figure demonstrates that most PCTs had a lower percentage of high banded residents in the later time period, although 12 had an increased percentage.

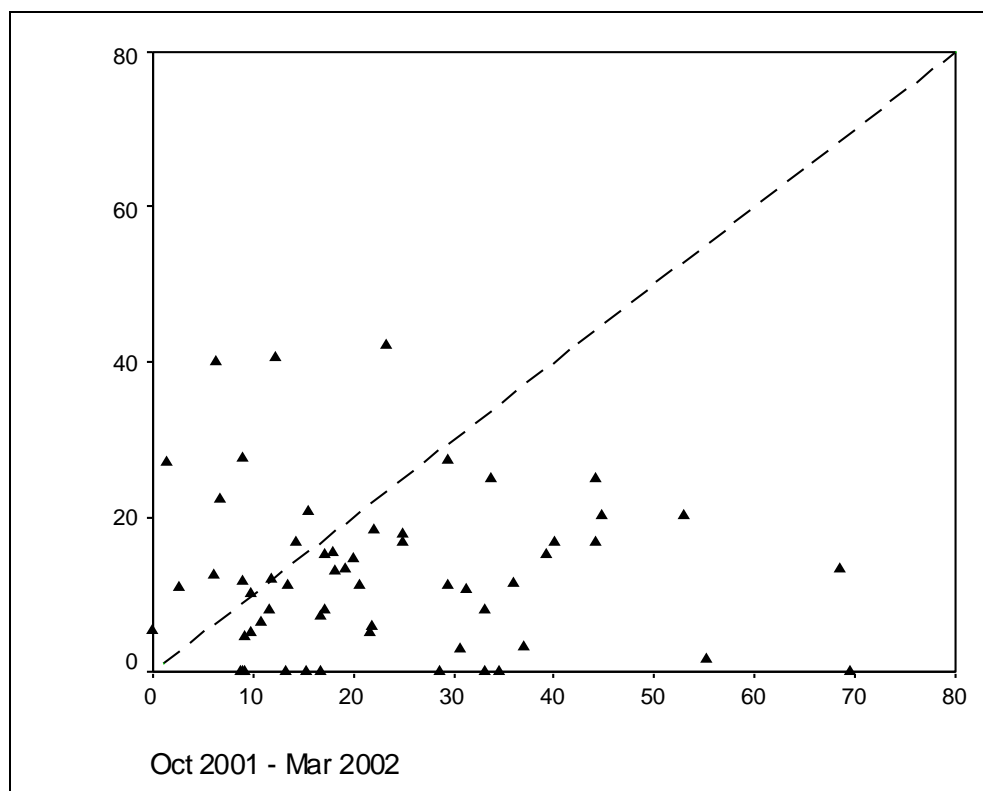
(ii) Low banding

Similarly, low banded residents varied with time. The top part of Figure 3.40 shows the percentage of self-funding residents banded low in the two periods (October 2001 - March 2002 and April - June 2002). The pattern here is noticeably different from the high band pattern. There were only two PCTs where the percentage of low banded residents had noticeably risen. Otherwise, the percentages in this band had either fallen or remained relatively stable over time.

Figure 3.39* : Percentage of high bandings per PCT for two time periods



2 survey (questionnaire AB)



* Stage 2 survey (questionnaire AB)

The bottom part of Figure 3.40 confirm this, providing a comparison of the percentage of low banded residents in each PCT in both time periods. Those PCTs above the line had a higher percentage of low banded residents during April to June 2002, and conversely for those below the line. It can be seen from this Figure that there was a distinct reduction in the proportion of patients banded low in the later period.

Thus, overall these two Figures demonstrate a trend for new residents to be allocated to a higher banding. This is presumably linked to the changing 'mix' of residents as determinations move from existing residents to new admissions. The latter are less likely to require low levels of RN care, especially if transferred from hospital.

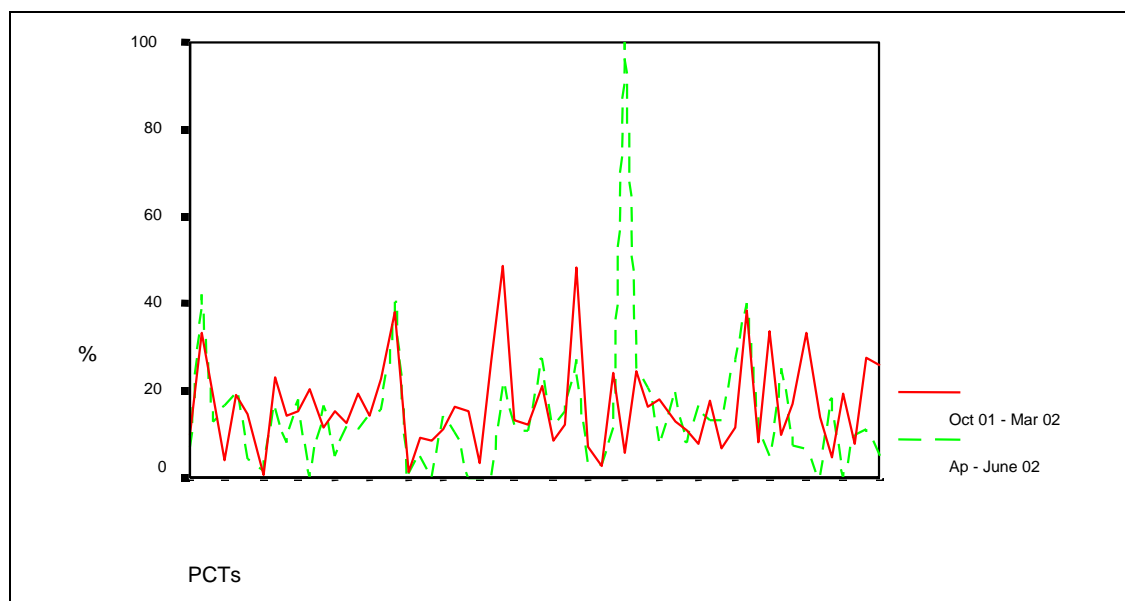
In fact, in the stage 2 survey (questionnaire CC) care home respondents were asked whether they agreed with the statement that their residents admitted from hospital were generally banded high but became medium or low band fairly quickly as their condition improved. Two thirds (62%) of care homes disagreed with this statement, although nearly one third (29%) did agree and 8% were uncertain and did not offer an opinion. Comments from stage 1 stakeholder interviews with PCT staff flagged up similar views, with some individuals also raising concerns about training for discharge liaison nurses to allow for the changing status of individuals:

"Discharge liaison nurses in hospital are assessing patients for nursing homes too early in their treatment - and resulting in much higher banding than necessary on discharge date. Therefore, re-assessment is required by teams" {stage 1 PCT interviewee}.

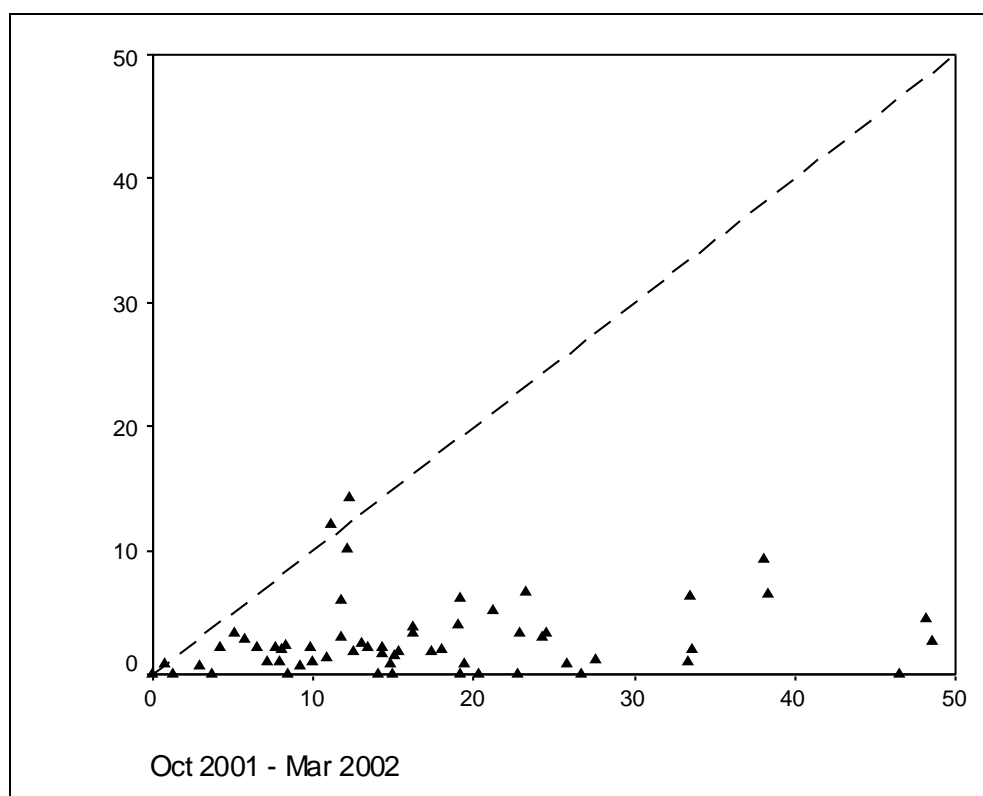
Of the one third of care home managers (questionnaire C) who had agreed with the statement that residents improve after admission and then fall into a lower banding, only one quarter said that a re-determination was undertaken to take account of the change in the resident's health status. Of those who said that a re-determination was undertaken, a few (7%) said that it took place within one week, a third (29%) said that it was within one month, and a fifth (21%) said that it took over one month to carry out the re-determination.

Almost half (45%) of all the care home managers (stage 1 questionnaire C) said that the re-determination took place as a result of their own request, a tenth (10%) said that it was the result of an appeal and a few (7%) said that it was at the request of others, usually the relatives or those with power of attorney. The remaining 38% did not answer this question.

Figure 3.40*: Percentage of low bandings per PCT for two time periods



* Stage 2 survey (questionnaire AB)

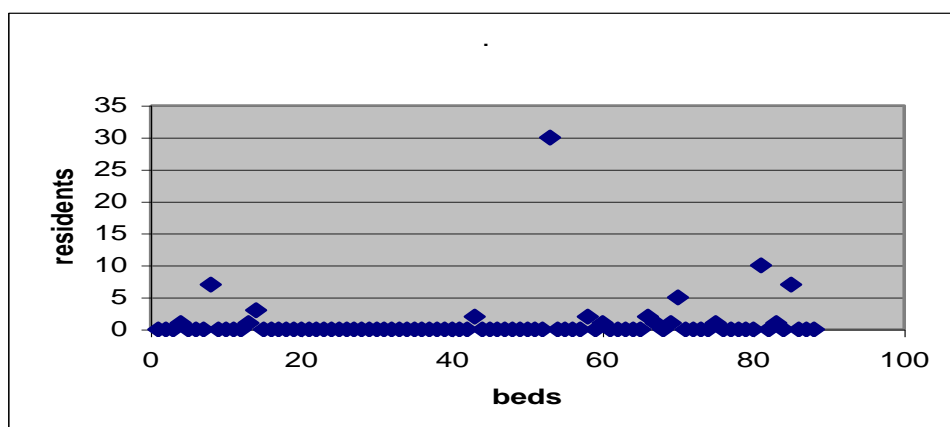


* Stage 2 survey (questionnaire AB)

(iii) Continuing care banding

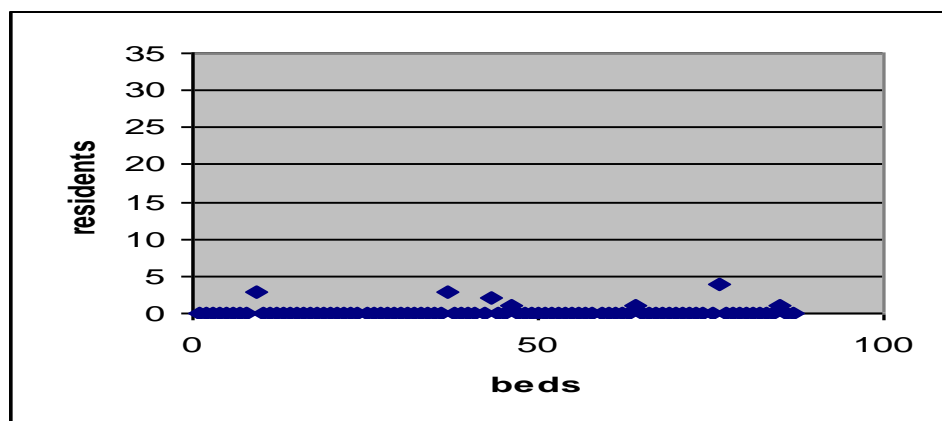
In some PCTs, self funding residents undergoing determinations were found to be eligible for continuing care, a higher funding level than the three RNCC bands. However, this occurred in relatively few PCTs and the number of residents involved was small, as shown in Figure 3.41. Furthermore, such cases had virtually disappeared in new admissions, as shown in Figure 3.42.

Figure 3.41*: Number of residents in continuing care band (October 2001 to March 2002)



*Stage 1 survey (questionnaire A)

Figure 3.42*: Number residents in continuing care band (April 2002 to June 2002)



* Stage 1 survey (questionnaire A)

3.5.3 Appeals and informal reviews

Appeals and informal reviews. The main findings were:

- In stage 1 interviews, regional, SHA, PCT and care home stakeholders generally reported a low level of appeals, but 'reviews' of RNCC outcomes were taking place at an operational level locally.
- Survey data for PCT appeals in the two time periods also showed low levels of appeals, and both the number of appeals and the number of PCTs reporting them decreased over time.
- PCTs generally reported appeal outcomes as more likely to result in a higher than a lower band from that originally determined, and this observation increased over the two time periods.
- The percentage of appeals in relation to determinations fell over the two time periods, but the likelihood of appeal increased in the later time period, as did the percentage of residents undergoing an appeal process.
- Most PCTs reported that the number of 'informal' reviews was 5 or less in the period 1st October 2001 and 31st March 2002 and the maximum number of reviews in any PCT was thirty.
- The main reason for appeals was either that the banding was too low, or there was a desire to move to continuing care funding. Appeals were generally reported to be prompted by relatives rather than residents, whereas, reviews were predominantly instigated as a result of a change in the resident's health status.

For individuals or their representatives who are dissatisfied with any aspect of their care, they may in the first instance, discuss this with the care home manager. If concerns relate to RNCC determination, they may then request an informal review via the co-ordinator/ lead nurse. If there is no resolution after an informal review, an appeal (formal review) may be requested via the continuing care panel (DoH 2001g).

In the stage 1 interviews, regional, SHA, PCT and care home stakeholders generally reported a low level of appeals, if any, against the banding outcomes of RNCC determinations in their area.

"Appeals - not aware of any " {stage 1 regional interviewee}.

"None that we have heard of at this organisational level" {stage 1 care home interviewee}.

"None, as far as I am aware - reviews are resolved locally by lead nurses" {stage 1 SHA interviewee}.

Instead, there appeared to be a recognition that 'reviews' of RNCC outcomes were taking place at an operational level locally. These reviews were mainly described as discussion between NHS staff, lead nurses, care home managers, relatives of residents and, if necessary, re-determination by a lead nurse. It was thought that reviews were mainly required because of misunderstanding of funded nursing care issues and that to date, such reviews had achieved an agreed outcome.

"We have no appeals - some 'reviews of outcome' but all are diplomatically resolved {stage 1 PCT interviewee}.

"Nursing home co-ordinators and relatives - all eventually agree outcomes" {stage 1 SHA interviewee}.

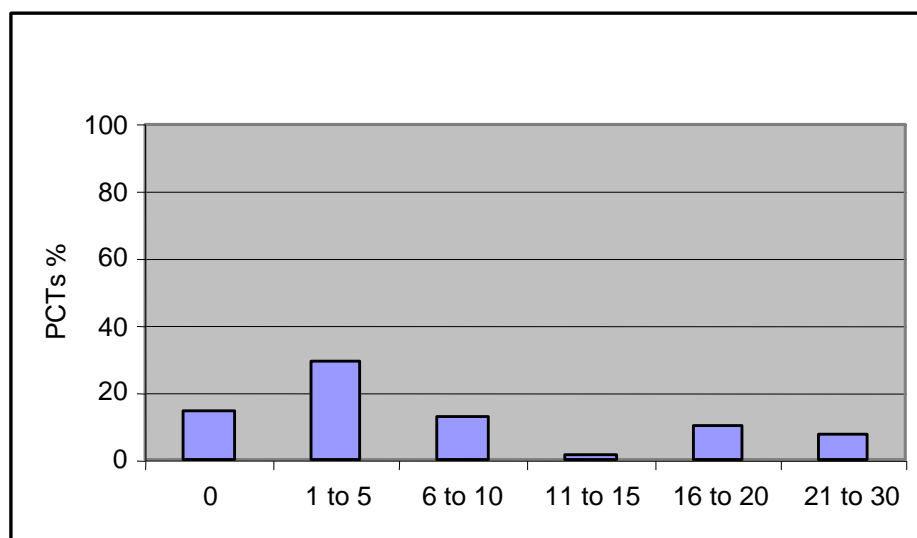
"There have been some discussions regarding outcomes but these have been resolved without appeal committees" {stage 1 care home interviewee}.

"Families raise issues for resolving. Nursing homes resolve issues with lead nurses. It is usually misunderstanding" {stage 1 care home interviewee}

(i) Informal reviews

The number of informal reviews for some PCTs (15%) was zero as shown in Figure 3.43 although 21% of PCTs did not answer this question so may have had none to report. For the 63% of PCTs who reported informal reviews, the number between April and June 2002 ranged from 1 to 30 in a PCT. Sixty percent of the informal reviews were undertaken because of change in health status, while 25% were undertaken because of a threatened appeal (formal review), sometimes combined with change in health status. For those PCTs who reported informal reviews, as a percentage of the total number of determinations between April and June 2002, informal reviews ranged from 11% to 89%, while the total number of determinations ranged from 15 to 61 in these PCTs. The PCT with the highest percentage of informal reviews had the lowest number of determinations.

Figure 3.43*: Number of informal reviews reported by PCTs



* Stage 2 survey (questionnaire AB)

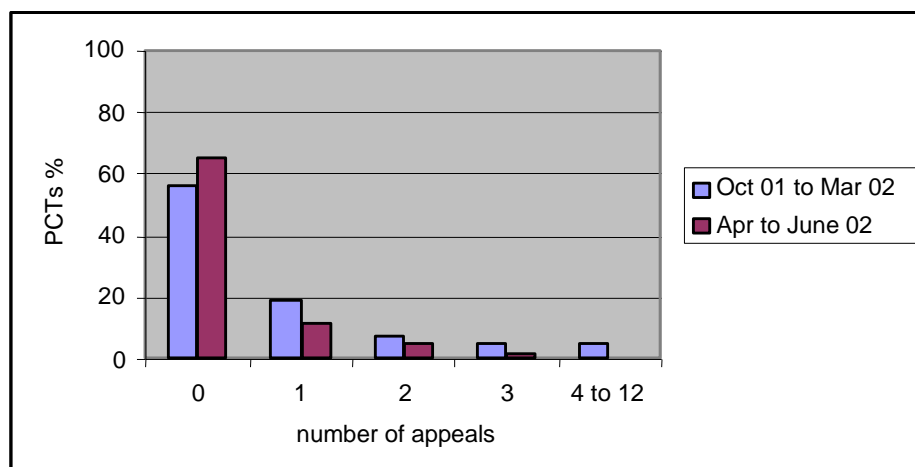
(ii) Appeals

The interview findings were confirmed by the surveys. Responses to the stage 2 survey (questionnaire AB) indicated that only one in seven PCTs (<15%) did not have an appeal (formal review) system in place

In the stage 1 survey (questionnaire A), co-ordinators/ lead nurses were asked how many appeals there had been for existing self-funding residents between 1st October 2001 and 31st March 2002. Although 40 PCTs (45%) reported appeals during this period, the numbers were very low as shown in Figure 3.44. The maximum number in any PCT was twelve, and the majority reported no appeals. For the subsequent period (1st April to 30th June 2002), even lower levels of appeals were recorded. Only 24 PCTs (35%) now reported any appeals, and the maximum number of appeals during this period in any

PCT was four. As a percentage of determinations in a PCT, appeals ranged from <1% to 11% between October 2001 to March 2002 and <1% to 3% between April 2002 to June 2002.

Figure 3.44*: Appeals as a percentage of determinations in PCTs



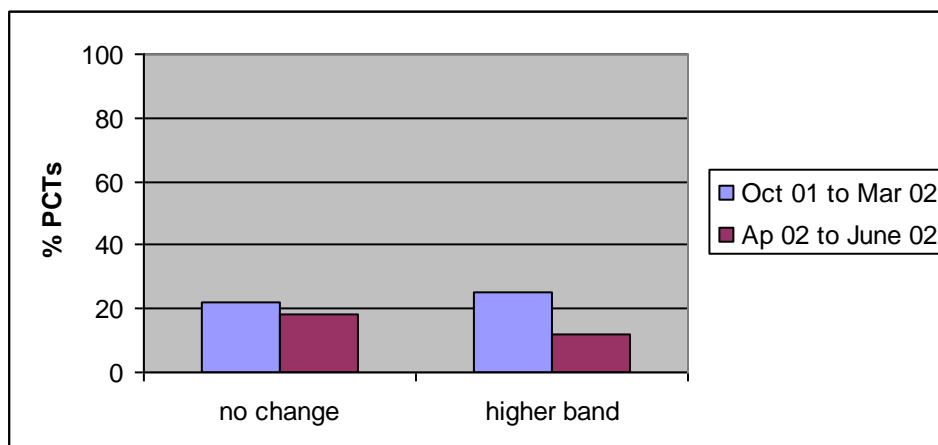
*Stage 1 survey (questionnaire A)

Only 7% of RNs reported in the stage 1 survey (questionnaire B) that they had been involved in appeals, while in the stage 2 survey 15% reported that they had been involved. Resolution of appeals was reported by RNs to be undertaken by co-ordinators/ lead nurses.

Figure 3.45 shows the outcomes of the appeals undertaken. When asked about the outcome of appeals and the results in relation to banding, between October 2001 and March 2002, only 23 PCTs (26%) reported change to a higher band, and 20 PCTs (22%) said that banding remained the same, while the remainder either did not answer the question or recorded zero residents.

Figure 3.45 shows the outcomes of the appeals undertaken. When asked about the outcome of appeals and the results in relation to banding, between April 2002 and June 2002, only 11 PCTs (12%) reported change to a higher band, 16 PCTs (18%) said that banding remained the same while the remainder either did not answer the question or recorded zero residents. Therefore the number of PCTs reporting change to a higher banding fell over time. No PCT reported that appeals led to a lower banding for residents in either time period.

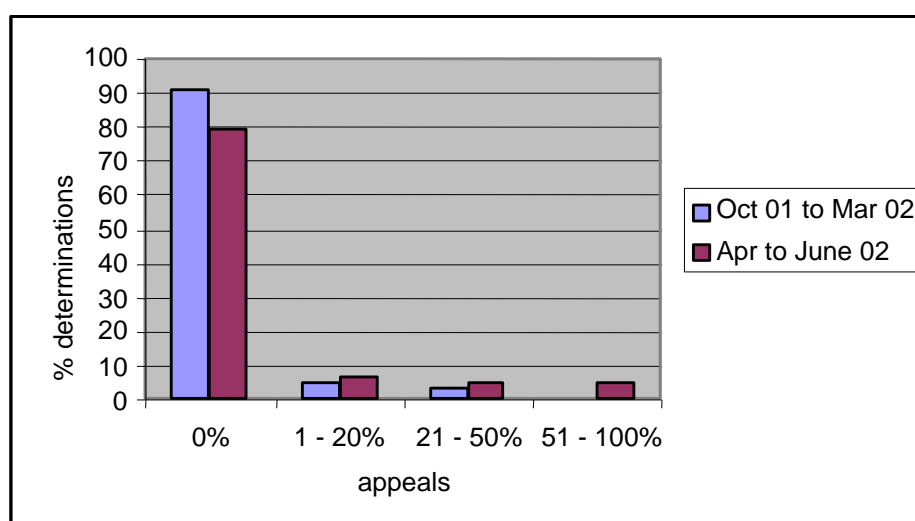
Figure 3.45*: Direction of change in banding following appeal



*Stage 1 survey (questionnaire A) for 1st October 2001 to 31st March 2002

Care homes were also asked in the stage 2 survey (questionnaire CC) how many appeals there had been for their residents in the same two time periods. The number of appeals (as a percentage of the total number of determinations in the care home) is shown in Figure 3.46.

Figure 3.46*: Appeals as a percentage of determinations in care homes



*Stage 1 survey (questionnaire C)

A very small percentage of care homes reported appeals. Two homes reported 100% appeals between April and June 2002, although they had relatively few determinations during this period (1 and 6). The majority of homes reported no appeals in either time period, although this percentage was falling (from 91% to 79%). The likelihood of appeal increased in the later time period, as did the percentage of residents undergoing an appeal process.

(iii) Triggers for appeals and informal reviews

Co-ordinators/ lead nurses/ RNs were asked in the stage 2 survey (questionnaire AB) what factors generally *triggered appeals* in their PCT. Seventy-two percent of respondents reported that appeals were instigated because it was considered that the banding was too low or there was a desire to move to continuing care funding. Appeals were generally reported to be prompted by relatives (77%) rather than residents (4%). Other people/ agencies initiating appeals included care home staff, solicitors and people with power of attorney for residents.

Reasons for *informal reviews* were reported to be primarily a change in health status (34%), a threatened appeal (6%), or a combination of both (17%). Other reasons included reviews aimed at moving the resident to the continuing care band with higher payments, and some open comments in the questionnaire stated that these had increased particularly after the Ombudsman's report in 2003.

3.6 ORGANISATIONAL IMPLICATIONS OF NHS FUNDED NURSING CARE

3.6.1 Stage 1 stakeholder views on implementation

Stage 1 stakeholder views on implementation. The main findings were:

- Several PCT and care home stakeholder interviewees indicated that the introduction of a banding system complicated the issue of funding for long term care, and few benefits were vocalised by either sector following the introduction of FNC for self-funding residents.
- Stage 1 interviews with key stakeholders indicated that one possible benefit was that the relationship between NHS and care home staff had improved.
- There was particular concern that the system would have to be streamlined in advance to cope with LA residents' determinations.

In stage 1 interviews, PCT and care home stakeholders expressed mixed views on the introduction of NHS funded nursing care. Some viewed the introduction of a banding system as only complicating the issue of funding for long-term care. These stakeholders were not convinced that the effort expended in arriving at RNCC bandings so far had been worthwhile.

"There is no benefit in banding as opposed to flat rate. There are many high band residents in this area. Time spent on assessments/determinations would be better spent on training nursing home staff and generally improving quality of patient care" {stage 1 PCT interviewee}.

"If a resident needs nursing care they need nursing care at the right time. There should be an evenly set up system. There is a high implementation hidden cost in this present FNC system." {stage 1 care home interviewee}.

"There is no 'free nursing care' and it is certainly not helping residents" {stage 1 care home interviewee}.

Others considered that the introduction of NHS funded nursing care had required PCT and care home nursing staff to work collaboratively together against a tight time-scale in order to achieve a number of pre-set government targets. As a result, the relationship between NHS and care home staff was said to have improved, with some suggesting that this was a positive outcome of the introduction of NHS funded nursing care.

"This [*relationship*] is much improved. This is probably the only positive outcome of the exercise" {stage 1 PCT interviewee}.

"It was difficult at first but now there is good access and liaison" {stage 1 PCT interviewee}.

In contrast, some care home stakeholders expressed the view that the relationship could be patronising.

"There is a hint of insult to nursing home staff - not competent in evaluating nursing care" {stage 1 care home interviewee}.

"Unites States uses nursing home staff to band their own residents. They know their nursing needs best" {stage 1 care home interviewee}.

There was, however, agreement that FNC caused major administrative problems. In the opinion of stakeholders in both sectors, the first round of implementation was thought to have been a 'paper exercise', because of the tight time scale set, although this was expected to improve.

"FNC care is causing a huge administrative problem with no obvious positive outcome for anyone, especially residents" {stage 1 PCT interviewee}.

"Initially it was just a paper exercise using care home patient documentation and liaising with care home staff – there was no time for anything else" {stage 1 PCT interviewee}.

"Many determinations were paper exercises rushed through with little time scale. Things should now improve as everyone understands the process" {stage 1 care home interviewee}.

It was also anticipated by many that there would be major issues if the process was not streamlined for the implementation of determinations for LA funded residents, with sustainability and careful planning both emerging as issues:

"If PCTs continue to administer the system in exactly the same way for LA residents as they have always done for self funders, there will be chaos" {stage 1 care home interviewee}.

"There need to be joint, key factor driven, resident care plans as a standardised agreed system - instead of vast amounts of resident documentation. This will streamline the system" {stage 1 care home interviewee}.

"We are setting up a bench marking sample of some LA homes as indicative of spread of bandings then [*we will apply*] RNCC tool in 6 months time for all LA residents" {stage 1 PCT interviewee}.

These issues, and other possible impacts, were explored further in the national surveys.

3.6.2 Impact of FNC on professionals' time, standards of care, care homes and residents

Impact of FNC on professionals' time, standards of care, care homes and residents. The main findings were:

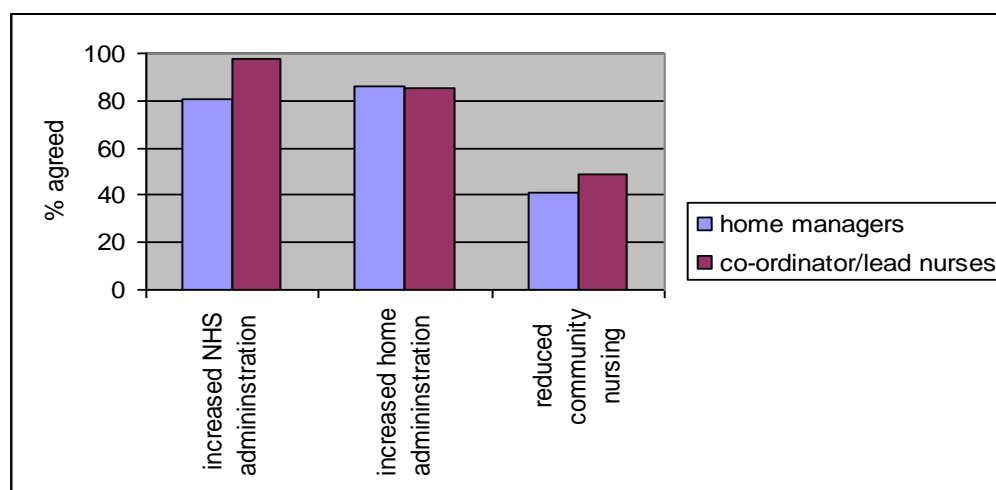
- Most PCT nurses agreed in the stage 2 survey that FNC implementation had resulted in more administrative time for both NHS staff and care home staff.
- Some one half of co-ordinators/ lead nurses and care home staff thought that implementation had impacted adversely on available community nursing time.
- Few of the care home staff surveyed in stage 2 believed that implementation of FNC had resulted in better standards of care for residents, although almost six times as many PCT nurses considered that funded nursing care had resulted in better standards of care.
- Three times as many PCT nurses as care home staff agreed that implementation of RNCC determinations had helped to improve the hospital discharge process, and more than twice as many PCT nurses also thought that admissions to homes had been streamlined
- Both care home staff and PCT nurses were in agreement that implementation of FNC had resulted in better value for money for self-funders in their area.
- Also, almost twice as many PCT nurses agreed with the statement that FNC had resulted in financial benefits for care homes than care home managers. Conversely, significantly more care home managers thought that FNC had reduced care home fees than did co-ordinators/ lead nurses.
- Approximately one in three of care home staff and PCT nurses identified that implementation of FNC had increased the number of closures of care homes.
- Almost three quarters of care home staff reported that their overall impression of NHS funded care was that it was fair for residents, but only a third thought that the impact of FNC on care homes was acceptable.

(i) Impact of FNC on professionals' time

The impact of FNC on administrative workload was followed up in the surveys. PCT lead nurses agreed in response to the stage 2 survey (questionnaire AB) that implementation of NHS funded nursing care had significantly increased workload for *both* NHS staff and care home staff (98% and 85% respectively), as shown in Figure 3.47. Care home staff (questionnaire CC) also identified a significant impact on both NHS and care home professionals (81% and 86% respectively). Only 15% of care home respondents thought that implementation had not placed an additional administrative burden on care homes.

More importantly, approximately half of co-ordinators/ lead nurses and care home staff thought that implementation had impacted adversely on available community nursing time. This is presumably a consequence of the points raised in earlier sections about lack of dedicated funding to cover RN time spent undertaking determinations.

Figure 3.47*: PCT and care home views on the impact of FNC on professionals



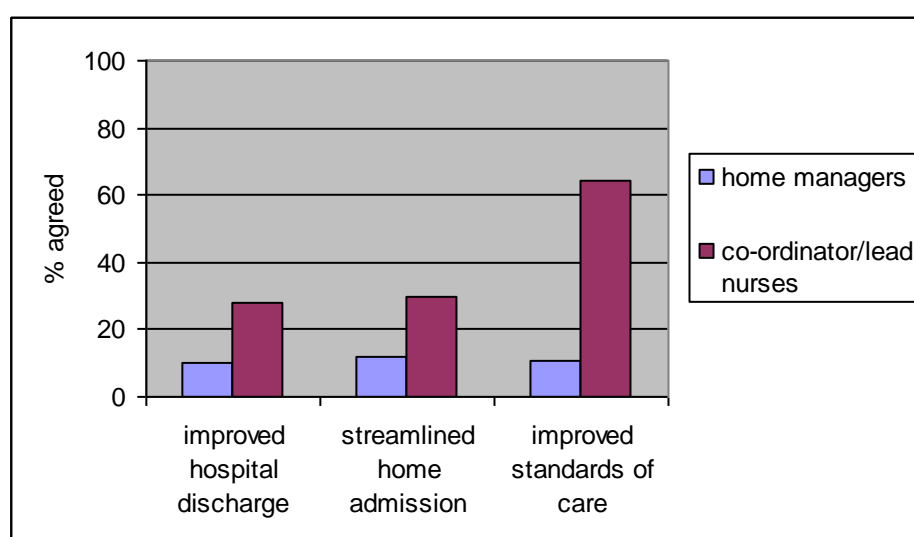
* Home managers: Stage 2 survey (questionnaire CC)

* Co-ordinators/ lead nurses: Stage 2 survey (questionnaire AB)

(ii) Impact of FNC on standards of care and process of admission to care homes

Although care homes and NHS staff were largely agreed about the impact of FNC on professionals' time, there was less agreement about any improvements in standards of care or impact on the admissions process. Very few care home managers reported in the stage 2 survey (questionnaire CC) that implementation of FNC had resulted in better standards of care for residents (11%). However, almost six times as many co-ordinators/ lead nurses considered that it had (64%). Results are shown in Figure 3.48. Concrete examples of improvements in patient care included provision of advice and proactive support for continence training, wound care, risk assessment, prevention of hospital admissions and shared knowledge.

Figure 3.48*: PCT and care home views on FNC impact on admissions/ standards of care



* Home managers: Stage 2 survey (questionnaire CC)

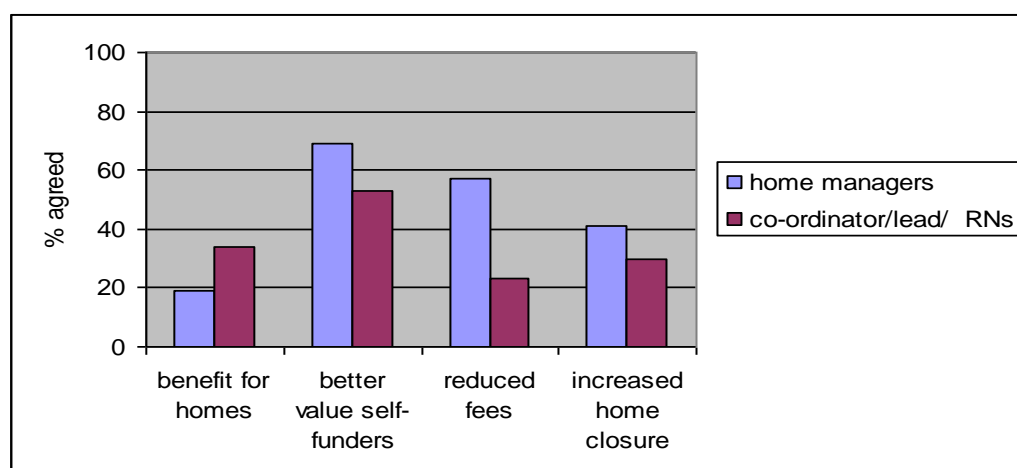
* Co-ordinators/ lead nurses: Stage 2 survey (questionnaire AB)

Similarly, co-ordinators/ lead nurses/ RNs were three times as likely as care home staff to agree that implementation of RNCC determinations had helped to improve the hospital discharge process (28% vs 10%) and had also streamlined admissions to homes (30% vs 12%).

(iii) Impact of FNC on care homes and residents

Care home managers were slightly more likely than PCT nursing staff to agree that implementation of FNC had resulted in better value for money for self-funders in their area as shown in Figure 3.49 (stage 2 surveys, questionnaires CC and AB respectively). Furthermore, almost twice as many co-ordinators/ lead nurses agreed with the statement that FNC had resulted in financial benefits for care homes (34% and 19% respectively). Conversely, twice as many care home managers considered that FNC had reduced care home fees (57%) as did co-ordinators/ lead nurses (23%). However, approximately one in three of both groups (30-40%) identified that implementation of FNC had increased the number of closures of care homes in their PCT. These responses illustrate largely similar views in both groups, with some key differences between NHS and care home staff..

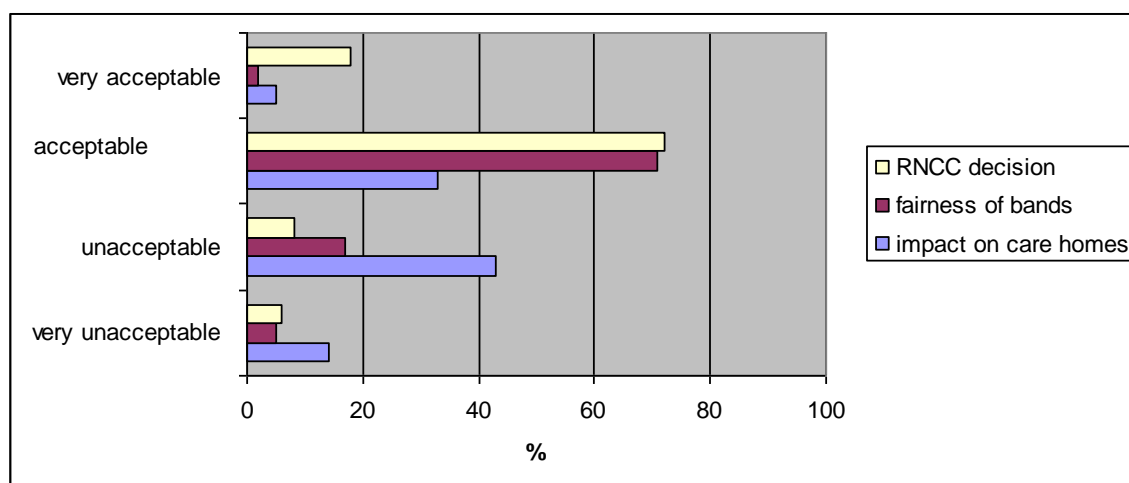
Figure 3.49*: PCT nurses and care home managers views on the impact of FNC on value for money, fees and home closures



* Home managers: Stage 2 survey (questionnaire CC) * Co-ordinators/ lead nurses: Stage 2 survey (questionnaire AB)

Care home staff were also asked (stage 2 survey, questionnaire CC) to rate the fairness of banding for residents and any impact of the RNCC process on care home professionals. They were also asked to rate the overall acceptability of any impact of NHS funded care on homes. The findings shown in Figure 3.50 indicate relatively high levels of acceptability for the RNCC process and the fairness of banding. However, the impact on care homes is considered to be far less acceptable.

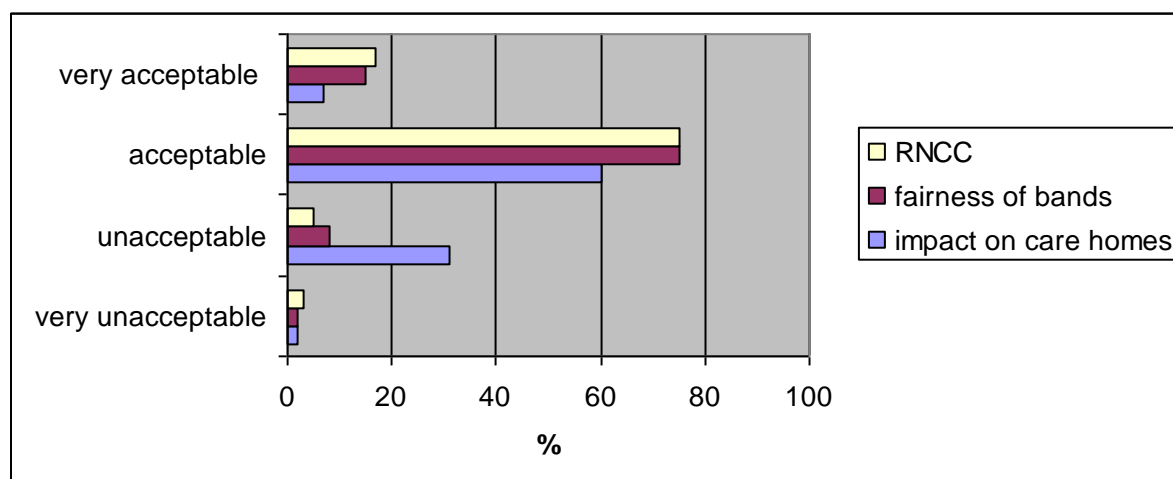
Figure 3.50*: Care home views on overall impact and fairness of FNC



*Stage 2 survey (questionnaire CC)

In contrast to care home views on overall impact and fairness of FNC, co-ordinator/ lead nurse/ RN views (questionnaire AB) were that the burden of FNC was unacceptable, shown in Figure 3.51.

Figure 3.51*: PCT views on overall impact and fairness of FNC



*Stage 2 survey (questionnaire AB)

3.6.3 Impact of FNC on developing relationship between NHS and care home staff

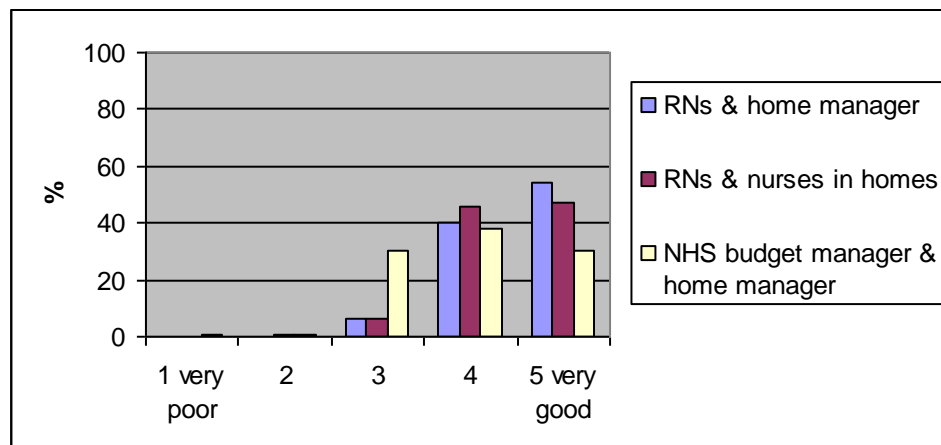
Impact of FNC on developing relationship between NHS and care home staff. The main findings were:

- The vast majority of co-ordinators/ lead nurses and RNs indicated that the relationship with the independent care sector was generally perceived as 'good' or 'very good'.
- When care home staff were asked comparable questions about their relationship with NHS staff in the stage 1 survey, similar responses to those given by co-ordinators/ lead nurses and RNs undertaking determinations were observed.
- Most co-ordinators/ lead nurses considered that the introduction of RNCC determination had *improved relationships* with care homes.
- Care home staff were far less likely to report that the relationship with NHS nurses had been improved.

(i) PCT staff views on relationship with care homes

In the stage 1 survey (questionnaire A), the opinions of co-ordinators/ lead nurses on their relationship with care homes were recorded on three dimensions, rated on a scale of 1= very poor to 5= very good. Responses are shown in Figure 3.52. These indicate that the relationship was generally perceived as 'good' or 'very good', with <3% reporting it to be 'poor' or 'very poor'. Mean ratings were as follows: relationship between NHS nurses and managers in homes 3.8; between RNs and nursing care staff in homes 3.5; and between NHS budget managers and managers in homes 3.8.

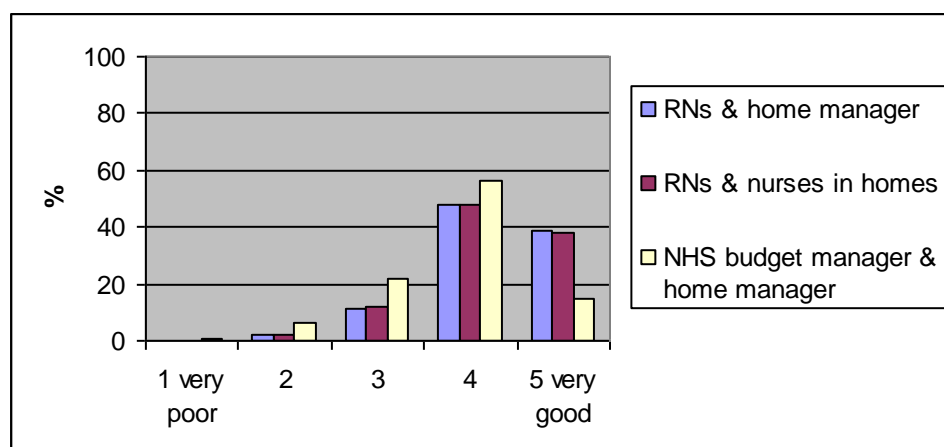
Figure 3.52*: Co-ordinator/ lead nurse views on relationship between NHS and care home' managers



* Stage 1 survey (questionnaire A)

RNs were also asked to rate their perception of the quality of their relationship with care homes for the same three aspects (stage 1 survey, questionnaire B). Responses are shown in Figure 3.53. Once again, these indicate very little evidence of relationships being reported as 'very poor' or 'poor' (<2% of respondents), and similarly very few reported poor relations between NHS budget managers and care home staff (<5%).

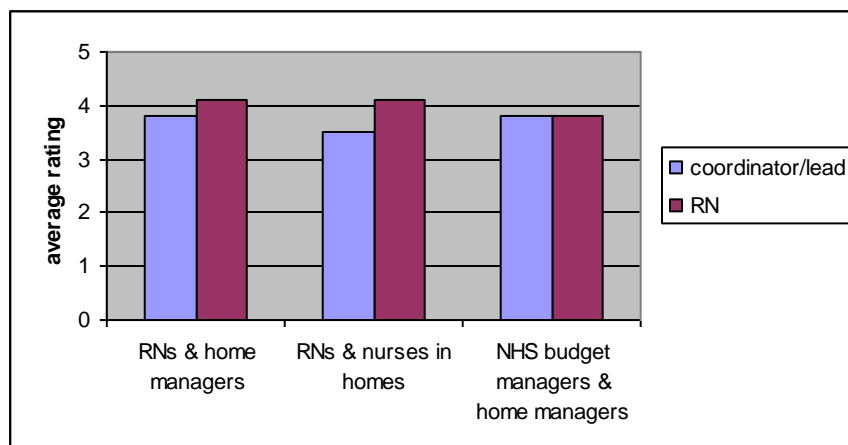
Figure 3.53*: NHS Registered Nurses' views on relationship between NHS and care homes' managers



* Stage 1 survey (questionnaire B)

RN mean ratings are generally slightly higher than those recorded by co-ordinators/ lead nurses, as shown in Figure 3.54.

Figure 3.54: Comparison of the views of co-ordinators/ lead nurses and RNs on the relationship between NHS and care homes' managers



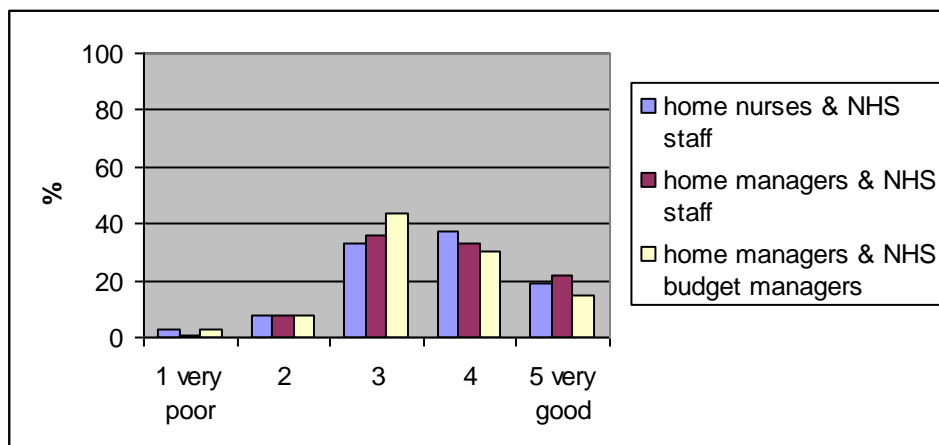
* Co-ordinator/ lead nurse (questionnaire A) * NHS RNs (questionnaire B)

The impact of RNCC determinations on the relationship between NHS staff and care homes was addressed in the stage 2 survey (questionnaire AB). Most PCT nurses (88%) considered that the introduction of RNCC determination had *improved relationships* with care homes. Improvement in relationships were thought to be due mostly to more contact with homes, increased awareness of roles, provision of training to care home staff, team working and annual conferences.

(ii) Care home staff views on relationship with NHS staff

Care home managers and senior nurses were asked comparable questions about their relationship with NHS staff in the stage 1 survey (questionnaire C). Responses are shown in Figure 3.55. This confirms that only a small minority (<7%) of care homes rated these relationships as 'low' or 'very low'.

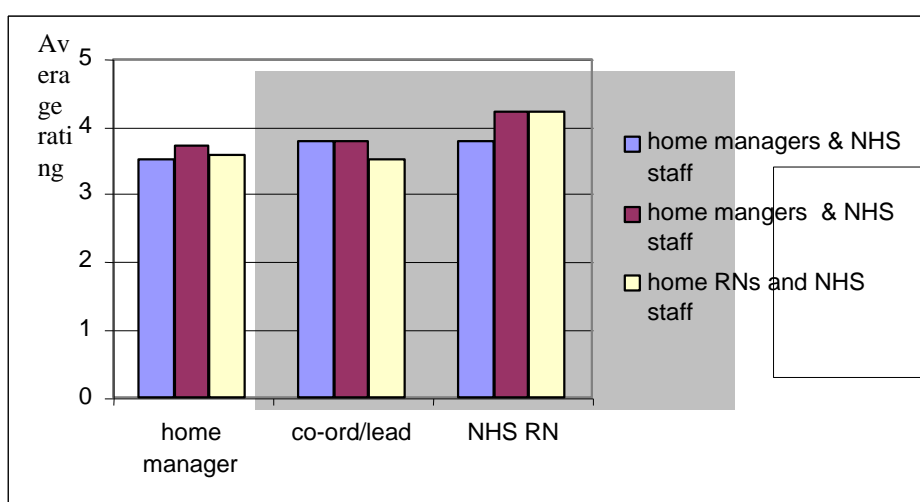
Figure 3.55*: Care homes' views on relationship between NHS and care home staff



* Stage 1 survey (questionnaire)

Figure 3.56 compares the average ratings of care home respondents with those of NHS staff. This demonstrates reassuringly similar views on the various types of relationship in all 3 groups (care home managers, co-ordinators/ lead nurses and RNs undertaking determinations).

Figure 3.56*: Comparison of the views of care home staff, co-ordinators/ lead nurses and RNs on the relationship between NHS and care homes



* Stage 1 surveys (questionnaires A, B and C)

However, there were differences in perception about the *impact* of FNC on the relationships between PCT staff and care homes. Co-ordinators/ lead nurses were far *more* likely (85%) to report that this relationship had been *improved* than were care home managers (4%).

3.6.2 Challenges to developing relationship between NHS and care homes

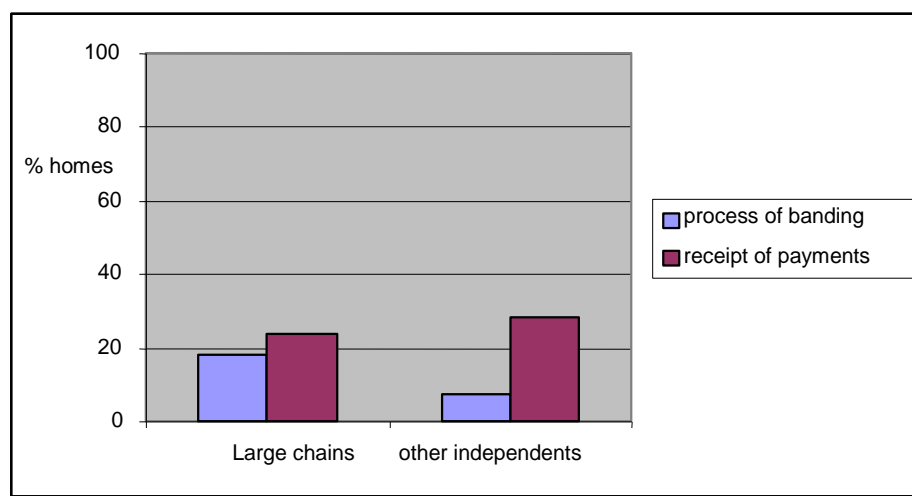
Challenges to developing relationship between NHS and care homes. The main findings were:

- Although fewer than one in five care home managers reported problems due to the RNCC determination banding process, slightly more identified payments as a problem.
- In stage 2, when care home key staff were asked about the promptness of RNCC payments, only one in five thought that payments were not prompt. Comparison with the views of co-ordinators/ lead nurses in the stage 2 survey indicated that only 6% reported that payments were not prompt.
- The majority of co-ordinators/ lead nurses reported that if payments were delayed, they were backdated to the home admission date.
- Hold up in payments was thought to be due mainly to administrative delays or communication problems from PCTs. Other reasons included computer delay and out of area transfers. Very few considered that lack of resources caused delay.

(i) Care home staff reported problems with FNC and their resolution

Fewer than one fifth (18%) of care home managers considered that there had been any problems due to RNCC determinations although slightly more (28%) identified receipt of payments as representing a challenge to their relationship with PCTs (questionnaire CC). Problems due to banding were more likely to be reported by large chain care homes, and issues linked to payments were more likely to be identified by the smaller independent homes (see Figure 3.57).

Figure 3.57*: Care home managers' views on relationship challenges with NHS



* Stage 2 survey (questionnaire CC)

Co-ordinators/ lead nurses (questionnaire A) were asked to describe the most common methods used for (a) identifying and (b) resolving any problems that might occur during the determination process between NHS staff and nurses in care homes.

Identification of problems was most likely to be through established reporting systems (44% of PCTs) whereas their *resolution* was reported to be mainly through the intervention of the co-ordinator/ lead nurse (66%). Other means of identification and resolution included: *ad hoc* discussions; annual visits

to care homes; follow up telephone calls; best practice meetings; direct contact instigated by care home managers; regular meetings; and reports from all care home managers at joint meetings.

(ii) RNCC payment systems

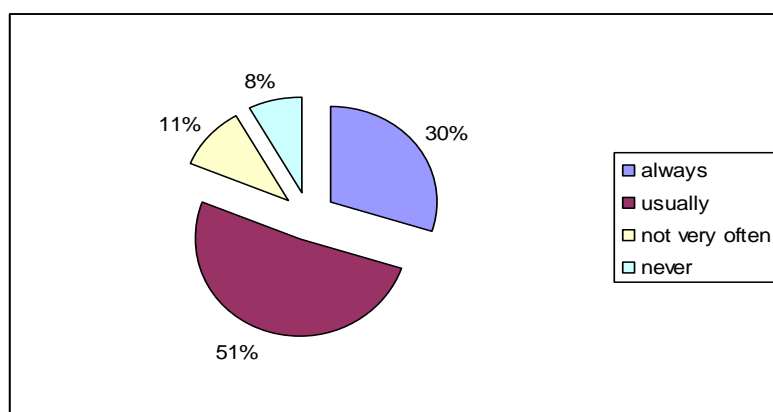
At the outset, interviews with stakeholders in stage 1 indicated that RNCC payment systems were identified as problematic early in the implementation process.

"It is a logistics nightmare. PCTs are not fully funded nor have they had guidance in the introduction of this system. Health Authorities are still involved in the system of payment. Payment is delayed and residents have died before it [FNC] is paid out" {stage 1 care home interviewee}.

"The payment process in some areas is extremely long and laborious with the invoice being sent to the RNCC co-ordinator who checks that the correct bandings and days have been charged. The invoice is then authorised, and the monies are transferred to the Local Authority for them to eventually pay, because the PCTs do not have the resources to pay. If a relative rings the PCT, the co-ordinator will tell them that the monies have been paid, but what is meant is that they have been transferred to the Local Authority for payment. When enquiring we are usually passed from person to person, with even the switchboards at PCT not having heard of RNCC or Free Nursing Care" {stage 1 care home interviewee}.

However by March 2003, when care home managers were asked in the stage 2 survey (questionnaire CC) about the promptness of RNCC payments, only one in five (19%) thought that payments were not prompt, as shown in Figure 3.58. Comparison with the views of co-ordinators/ lead nurses/ RNs in their stage 2 survey (questionnaire AB) indicates that only 6% reported that payments were not prompt. The majority of PCT nurses (94%) also reported that if payments were delayed they were backdated to the home admission date. Hold ups were thought to be due mainly to administrative delays (52% of PCTs) or communication problems (20% of PCTs). Other reasons included computer delay and out of area transfers. Very few (2%) considered that lack of resources caused delay.

Figure 3.58*: Care home managers' views on promptness of payment of RNCC payments



* Stage 2 survey (questionnaire CC)

3.7 CONTINENCE AIDS/ SPECIALIST EQUIPMENT

As pointed out in the Introduction, incontinence is a key issue for care homes, partly because many residents suffer from it, but also because there are high resource costs if it is poorly managed. Access to specialist equipment is also an important issue, especially for the prevention of pressure sores.

As part of the first phase of implementation of RNCC determinations, £6m was made available in England for PCTs or Community Trusts to make arrangements for provision of continence promotion aids and specialist equipment; this funding covered the period 1st October 2001 to 31st March 2002 (HSC2001/17: LAC (2001)26). Thus, in addition to undertaking RNCC determinations, PCTs were also expected to identify the number of residents (initially self-funding) requiring continence aids and equipment and undertake an assessment.

The *National Standards for Care Homes in England* had set out, among other things, the minimum levels of equipment that care homes should provide, including continence promotion aids. Availability of continence aids and other specialist equipment in care homes was also included in the monitoring role of the National Care Standards Commission (NCSC), set up by the government in April 2002.

3.7.1 Overview of implementation of continence assessments

Overview of implementation of continence assessments. The main findings were:

- The interviews in stage 1 with Regional and SHA stakeholders suggested that geographical variations negatively influenced the purchase of preferred continence products, and led to a lack of choice over products. Some SHA stakeholders identified the setting up of joint funding initiatives by PCTs with social services in the area of continence aids, and of systematic profiling of needs.
- Issues surrounding equipment included: a lack of knowledge of what equipment could be purchased, the increased burden of cost for equipment, and the need to involve care homes in decision-making. There were perceived to be cost containment pressures, and particular difficulties were anticipated for smaller care homes.
- Several care home stakeholders, particularly from the larger chains, thought that their existing systems and expertise were not acknowledged. Issues arising comprised: the practical problem of storage following bulk deliver of continence products; their lack of inclusion in continence assessments that were perceived as progressing slowly; the lack of clarity about what equipment was included, and who held the supply responsibility.
- PCT stakeholders generally reported that they were providing about £5 per week for incontinent residents. Some PCTs were concerned about disparities arising between self-funders and others, that might lead to self-funding residents being penalised. Although a majority of these stakeholders indicated that planning was in progress in late 2002 for continence assessments, this had not been implemented and some PCTs assumed that the RNs undertaking determinations would also carry out these assessments; whilst others had referred residents to a specialist continence advisor.
- Both PCT and care home stakeholders reported that where there was cross-working with Social Services for continence and equipment provisions, this was viewed positively.

(i) *Regional view on continence assessments*

Regional stakeholders interviewed in stage 1 voiced worries over the provision of continence promotion aids and other equipment, observing that geographical variations were emerging such that in some areas care homes were able to purchase their usual, preferred continence products and in others specific products were provided with no choice.

"There are varying arrangements for continence Some health authorities pay £4 per person per week and others are providing from their own stores" {stage 1 regional interviewee}.

There were also issues emerging about which items of specialist equipment should be covered by the funding provided.

"There are funding problems with the provision of specialist equipment as there is no real definition of what should be funded" {stage 1 regional interviewee}.

(ii) *Strategic Health Authority view on continence assessments*

Strategic health authority stakeholders expressed similar views to those of the regional stakeholders, identifying lack of choice for continence aids as an issue in some PCTs. However, the stakeholders interviewed were even more concerned about the funding of specialist equipment.

"Equipment is a nightmare, money is a drop in the ocean" {stage 1 SHA interviewee}.

"This is a huge additional burden for funding authorities" {stage 1 SHA interviewee}.

"Specialist equipment is a headache. Some HAs have contracts to supply continuing care specialist beds to nursing homes. We are appointing a tissue viability nurse to support this" {stage 1 SHA interviewee}.

"Special equipment list needs to be reviewed with nursing homes" {stage 1 SHA interviewee}.

It was acknowledged also that equipment was an issue for care homes.

"The National Care Standards Commission emphasised that nursing homes should be equipped for the level of care they advertise - but this is not always the case" {stage 1 SHA interviewee}.

"Smaller nursing groups have a bigger problem here" {stage 1 SHA interviewee}.

However, some SHA stakeholders also identified that PCTs were setting up joint funding initiatives with social services in the area of continence aids, and undertaking systematic profiling of needs.

"There is some pooling of funds between social services and PCTs, as in old health authorities" {stage 1 SHA interviewee}.

"There will be profiles [*continence aids & specialist equipment*] of needs for self-funders and local authority residents" {stage 1 SHA interviewee}.

"There are some early discussions about joint funding initiatives" {stage 1 SHA interviewee}

"Our local equipment service is now joint funded. There are lists of equipment which care homes should have to be viable. For example, wheel chairs and specialist beds are a major issue" {stage 1 SHA interviewee}.

(iii) Care home views on continence assessments

Care home stakeholders interviewed in stage 1 also identified continence aids as an issue of contention. Several care home stakeholders, particularly those from the larger chains, thought that their existing systems and expertise were not acknowledged.

"Our nursing homes were well organised in continence care and now the NHS is insisting that they change our contracts. We are getting inferior products and reduced provision per resident. They are also making us change our well established supply contractors who provided our nursing home staff with good training" {stage 1 care home chain interviewee}.

"Our staff were well trained in continence management before. Now they are not happy and feel their residents are suffering" {stage 1 care home interviewee}.

"Residents are losing out in continence issues as we had high quality provision with free staff training prior to free nursing (sic). There is now no contract evaluation no choice" {stage 1 care home interviewee}.

"We have just done an evaluation of continence issues and some PCTs are still not funding this for self-funders and are suggesting Kylies [*padded pants*] at night" {stage 1 care home chain interviewee}.

In cases where the PCT provided continence aids in bulk, there were practical problems for some homes in terms of storage.

"The continence issue has caused severe storage problems as health authorities insist in sending bulk supplies of several weeks and this is a fire risk" {stage 1 care home interviewee}.

"The problem of huge supplies of continence aids is gradually being resolved by more regular deliveries - but staff are not happy. There is a much inferior service than before determination" {stage 1 care home interviewee}.

Only a minority of care home stakeholders expressed satisfaction, particularly where staff training was now being provided.

"Have not heard of any continence issues in this organisation" {stage 1 care home interviewee}.

"Our staff are happy that NHS staff are providing unbiased training" {stage 1 care home interviewee}.

In contrast with the conduct of determinations, in many parts of the country progress was reported to be slow in carrying out continence assessments. Once again, some care home nurses thought their expertise was not being used and that they could contribute more to the process.

"Many residents have not been continence assessed. The NHS staff do not accept nursing home staff assessment of continence and the whole exercise is prolonged. PCTs then give a year's supply of inferior continence aids and advice" {stage 1 care home interviewee}.

"This is patchy throughout the country (no pun intended) with some homes not yet having been assessed for continence issues. Some homes have been assessed but have yet to receive monies. Some homes received interim monies at first but are now receiving supplies. The rates for single and double incontinence are sometimes different for every resident. Some authorities pay £4 per week for single and £6 per double but some allow as much as £8 a week for a single. It is not regulated and appears to be at the whim of the PCT" {stage 1 care home chain interviewee}.

Specialist equipment was also singled out as a particular area of concern by care homes in the stage 1 interviews. Provision appeared to be variable nationally, there was a lack of clarity about what equipment should be included, and some confusion over whose responsibility it was to supply what.

"Provision is extremely variable from local authorities" {stage 1 care home chain interviewee}.

"Appropriate nursing equipment needs further definition. This is a continuous problem" {stage 1 care home interviewee}.

"PCTs are saying nursing homes are responsible for supplying all equipment" {stage 1 care home chain interviewee}.

There were also perceived to be cost containment pressures, and particular difficulties were anticipated for smaller care homes.

"PCTs have social services representatives at that level and they are politically motivated to keep equipment budget down" {stage 1 care home interviewee}.

"Large nursing home organisations are well-equipped but smaller homes will struggle" {stage 1 care home interviewee}.

Where the NHS and Social Services were working together, however, the benefits were viewed in a positive light.

"Health and Social Services have a joint pool of equipment e.g. Nimbus beds [*air beds for pressure sore prevention*] and our nursing homes have access to this" {stage 1 care home interviewee}.

(iv) PCT views on continence assessments

PCT stakeholders generally reported in their stage 1 interviews that they were providing about £5 per week for incontinent residents, although in some cases this had until recently only been £4 per week. Some PCTs were worried about disparities arising between self-funders and others that might lead to self-funding residents being penalised.

"We give 75p per day per incontinent resident. This was recently increased from 60p" {stage 1 PCT interviewee}.

"Seventy-five pence daily is funded for all self funding incontinents. But continence advisor is concerned as Social Services pay for continence support for all their residents" {stage 1 PCT interviewee}.

Some PCTs had already appointed continence staff to work in care homes.

"We have appointed Continence support and tissue viability nurse to assist in nursing homes and this is well accepted" {stage 1 PCT interviewee}.

But the majority, although they had plans in progress, had not yet (late 2002) implemented these, including training of care home staff. Some PCTs were assuming that their RNs, who were undertaking determinations, would also be able to carry out continence assessments; whilst others were referring residents to a specialist continence advisor.

"We are planning to integrate continence assessment with review of determinations" {stage 1 PCT interviewee}.

"RNs carrying out determinations will include continence assessments in future and they will also train staff in continence management" {stage 1 PCT interviewee}.

"We now provide products and we will provide training" {stage 1 PCT interviewee}.

"We are asking that self-funding residents will be referred to our continence advisor whose extended new role will be to train nursing home staff in continence management" {stage 1 PCT interviewee}.

Provision of specialist equipment was also proving to be a major issue for many of the PCTs interviewed. Even if it was viewed positively *in principle*, PCTs were quite open about the problem of rising costs, an issue already picked up by care home respondents.

"A minefield of problems. There are no clear definitions for specialist equipment and misunderstanding abounds" {stage 1 PCT interviewee}.

"It sounded as if it was a good idea but there is not enough funding available" {stage 1 PCT interviewee}.

"Determinations have had a high impact on our Home Loans Service especially on pressure relief" {stage 1 PCT interviewee}.

Once again, where PCTs reported that they were working with Social Services this was reported positively.

"We have a joint pool of specialist equipment at health authority level. Nursing homes, Social Services and domiciliary residents all have access - and this works" {stage 1 PCT interviewee}.

3.7.2 National surveys on continence aid and equipment assessments

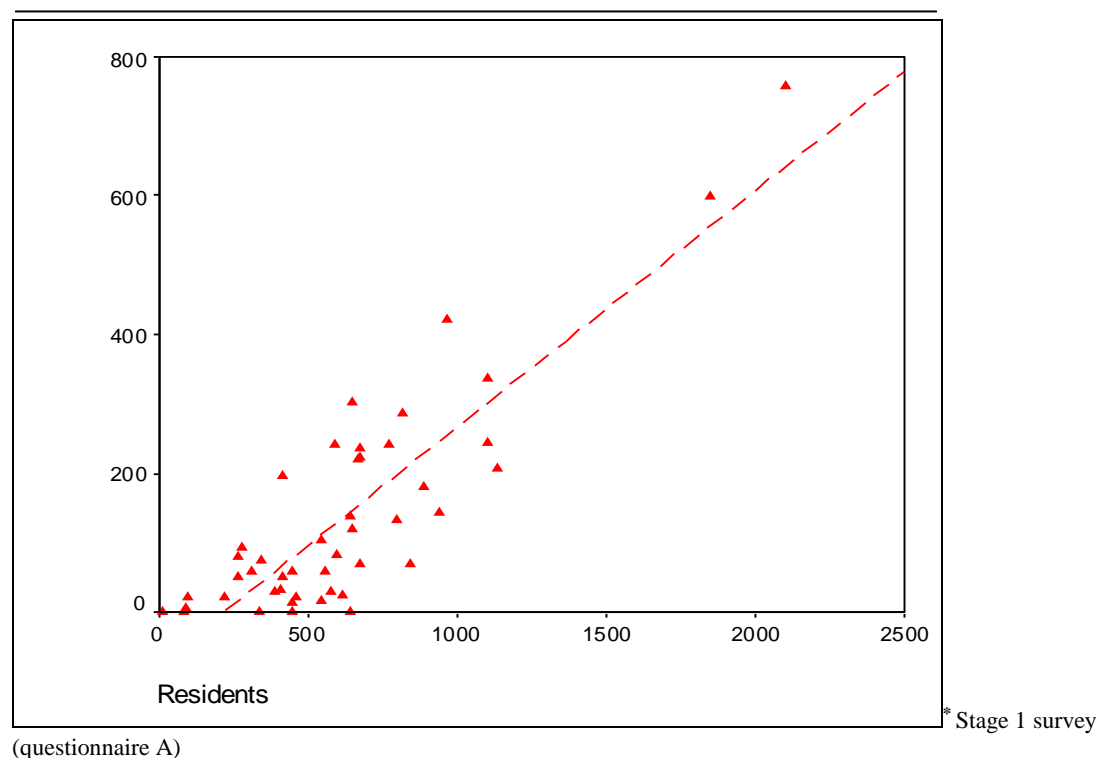
National surveys. The main finding were:

- The majority of co-ordinators/ lead nurses (53%) reported that their PCT supplied continence aids to homes, a quarter (24%) reported that the PCT paid a fee to the home, a few (2%) said that they supplied aids *and* paid fees to homes, and the remaining 21% did not answer the question.
- In terms of the relationship between continence assessments and RNCC banding, PCT nurse co-ordinators/ lead nurses in stage 1 reported that up to three quarters of the high band residents required continence aids, as did a similar proportion of those in the medium RNCC band, but none of the residents banded low required continence aids.
- In stage 1, co-ordinators/ lead nurses provided information on the number of specialist equipment assessments conducted in their PCT between April 2001 and March 2002, and a large proportion reported that they had undertaken no assessments as yet.
- In half of PCTs, specialist equipment assessments were performed by RNs (47%) and OTs (45%) Other professionals included community nurses (40%), independent sector nurses (23%) and social services (22%). Most PCTs used all these professionals. For those who had conducted specialist equipment assessments, 2% reported that residents were assessed by specialist nurses, while a further 2% stated that assessment was undertaken by a tissue viability nurse. Over half of RNs (58%) had undertaken specialist equipment assessments involving between 1 and 50 residents. The main types of specialist equipment needs identified were linked to prevention of pressure sores.
- When stage 1 PCT co-ordinators/ lead nurses were asked about the outcomes of specialist equipment assessments for residents placed in different RNCC bands, a third of residents in the medium band and two thirds of those in the high band needed specialist equipment. No residents in the low band were reported as needing specialist equipment.

(i) National survey of continence assessments

In stage 1, over two thirds of RNs (68%) had undertaken continence assessments, ranging from 1 to 223 residents (questionnaire B). In the stage 1 survey, co-ordinators/ lead nurses were asked for details of the number of continence assessments completed (questionnaire A); statistics were generally available only for the 12 month period between April 2001 and March 2002. Results are shown in Figure 3.59; the best fit line indicates that at most approximately one third of those who had undergone a determination had also had a continence assessment. Thirty seven per cent of PCTs reported that they had undertaken no continence assessments during this period. There was no clear reason why these PCTs had not undertaken continence assessments e.g. number of RNs or residents undergoing determination.

Figure 3.59*: Contenance assessments undertaken in PCTs April 2001 to March 2002



In stage 2, (questionnaire AB) of those who had undertaken continence assessments, half of PCTs, assessments were performed by social services (53%) and independent nurses (43%). Other professionals included RNs (40%), community nurses (21%) and physiotherapists (6%), occupational therapists (<1%). Most PCTs reported that they used all these professionals.

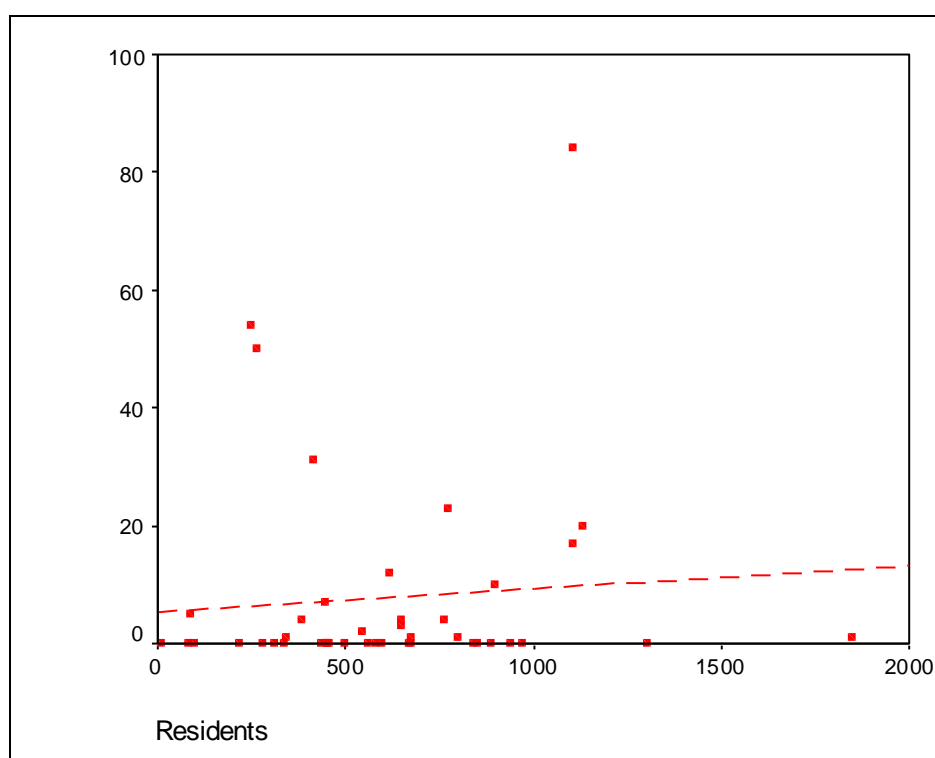
In stage 1 (questionnaire A) PCT nurse co-ordinators/ lead nurses were asked for information on the outcome of continence assessments for self-funding residents placed in different RNCC bands. For residents placed in the high band, between 22% and 74% required continence aids, as did a similar proportion (5% and 71%) of residents in the medium RNCC band. There were no residents requiring continence aids who were banded low.

Because of the views of stakeholders reported in stage 1, highlighting the lack of choice for continence aids as an issue in some PCTs, respondents were also asked about the type of provision in their PCT. The majority of co-ordinators/ lead nurses (53%) reported that their PCT supplied continence aids to homes, a quarter (24%) reported that the PCT paid a fee to the home, a few (2%) said that they supplied aids *and* paid fees to homes, and the remaining 21% did not answer this question.

(ii) National survey of specialist equipment assessments

In stage 1, fewer than two thirds of RNs (58%) reported that they had undertaken specialist equipment assessments involving between 1 and 50 residents (questionnaire B). At the same stage (questionnaire A) co-ordinators/ lead nurses were also asked to provide information on the number of specialist equipment assessments conducted in their PCT between April 2001 and March 2002. The results are shown in Figure 3.60; the best fit line indicates that approximately 3% of those who had undergone a determination had also had a specialist equipment assessment, a much lower figure than for continence assessment. Three quarters of PCTs (75%) reported that they had undertaken no assessments yet, compared with 37% of PCTs who reported no continence assessments. Once again, there was no clear reason why these PCTs had not undertaken specialist equipment assessments e.g. number of RNs or residents undergoing determination.

Figure 3.60*: Specialist equipment assessments in PCTs April 2001 to March 2002



* Stage 1 survey (questionnaire A)

In stage 2 (questionnaire AB) of those PCTs who had undertaken specialist equipment assessments, half were performed by RNs (47%) and occupational therapists (45%). Other professionals included community nurses (40%), independent sector nurses (23%) and social services (22%). Most PCTs used all these professionals. For those who had conducted specialist equipment assessments, 2% provided free text information that residents were assessed by specialist nurses, while a further 2% stated that assessment was undertaken by a tissue viability nurse.

The main types of specialist equipment needs identified were linked to prevention of pressure sores, including: airflow mattresses; beds; dynamic overlay mattresses; high risk pressure relieving equipment; Nimbus III mattresses; profiling beds, and very high risk pain relief mattresses. Other equipment included: suction machines, enteral feeding equipment, drip stands, ventilators, humidifiers and cushions.

Once again in stage 1 (questionnaire A), when PCT nurse co-ordinators/ lead nurses were asked about the outcomes of specialist equipment assessments for residents placed in different RNCC bands, it was reported that between 14% and 100% of residents in the high band required specialist equipment and between 7% and 100% of those in the medium band. No residents in the low band were reported to need specialist equipment.

CHAPTER 4

FINDINGS FROM STAGE 3: IN-DEPTH QUALITATIVE STUDY

4.1 INTRODUCTION

To provide a context for the reader, a summary of evidence on the management of NHS funded nursing care, derived from stakeholder telephone interviews (field notes) collected during stage 1, and the in-depth interviews for stage 3 (audio-taped and field notes) is presented in Table 4.1. As can be seen, the management structure adopted by both localities during implementation was similar. Initially, one nurse undertook determinations, there was the involvement of senior management, and budget holders took the co-ordinator role, but with no appointment of either a lead nurse or a combined lead nurse/ co-ordinator post. However, by stage 3, *locality one* had adapted their management structure with a separate lead nurse and co-ordinator appointments, whereas in *locality two*, these roles were combined into one. Both localities had also moved towards involving more than one RN to undertake determinations. *Locality one* had a written FNC strategy for implementation but this was not evident for *locality two*. Both *locality one and two* used hand-written recording systems during implementation but both had moved to computer-based systems by stage 3 (data entered by hand from printed sheets) with *locality two* using both NHS and social services' databases.

Throughout the study period, *locality one* had an identified FNC budget within a 'pool', whereas this only became evident in *locality two* at the time of stage 3. Although there were differences between the localities in terms of initial FNC training, both localities adopted a PCT cascade system for training over time. During implementation, neither of the localities had an appeals committee, or quality assurance mechanisms. However, by stage 3, both localities had appeals committees set up, but *locality two* still did not have quality assurance mechanisms in place.

In Stage 3, in-depth interviews were used to enhance interpretability and expand on the findings from the stakeholder interviews and questionnaire surveys in stages 1 and 2 (Gomm, Needham and Bullman, 2000). The over-arching purpose of the in-depth interviews was a further exploration of a number of issues that may not be answered by quantitative methods alone, but are considered to be of substantial practical importance (Murphy and Dingwall, 2001:166). The combined contribution of qualitative and quantitative methods collectively have a valuable role in the analysis of data for health services research (Barbour, 1999), in developing a greater understanding of some of the more complex issues facing health care changes, and where this research 'fits' in the current health delivery environment (Banister et al., 1995). This is especially the case if these methods are used together to address divergent and complementary questions - the concept of *triangulation* (Huberman and Miles, 1998). Adopting this

approach provides a narrowing of focus and increasing depth, or richness, of data to further expand on the survey's findings by making the implicit findings and assumptions more explicit (Giorgi, 1995). Furthermore, mapping the quantitative analysis from the survey results with the qualitative interpretations of the interview data acts as a credibility check (Elliott, Fischer & Rennie, 1999) and ensures rigour in the research process (Henwood and Pidgeon, 1992). The overall approach was, therefore, to aim for a 'democratization' of the research process and a synthesis of methods (Oakley, 2000: 21).

Table 4.1 Descriptive Details of Localities 1 and 2 During Initial Implementation (Stage 1) and Subsequent Adaptations (Stage 3)

Activity	Initial implementation stage		Subsequent adaptations	
	Locality One	Locality Two	Locality One	Locality Two
Acting Lead Nurse		√		
Project lead and determinations	√*			√
Co-ordinator	√ (<i>Finance manager</i>)	√ (<i>Finance manager</i>)		√ (<i>Finance support</i>)
Lead Nurse				√
Co-ordinator/ Lead Nurse			√	
One RN undertaking determinations	√*	√		√
More than one RN undertaking determinations.			√	
Use RMN for EMI residents			√	
Team approach for determinations			√	
Provided written FNC strategy	√			
Support for administration			√	√
Budget and Records				
Budget for training/management identified within pool	√		√	√
Hand recorded	√	√		√
Using NHS database			√	
Using Social Services database				
Training				
DoH		√		√
Region	√			
PCT Cascade	√	√	√	√
Outcome Mechanisms				
Appeals committee			√	√
QA mechanisms			√	
Reviews undertaken			√	

*combined role as lead nurse and RN for determinations

4.2 METHOD STAGE 3

4.2.1 Purpose of interviews

In stage 3, the in-depth study in the two locations explored some of the issues arising from the findings of stages 1 and 2 which were discussed earlier (Chapter 3). Practical aspects of applying the RNCC determination tool in the implementation of the roll out nationally were also explored with the participants in this phase of the research. Interview themes were initially developed using the responses from participants who returned a questionnaire in the first survey (stage 1). However, these themes were not prescriptive, so that participants were left free to discuss any issues that they considered of relevance on the theme (determination of NHS 'free' nursing care). In this way the study was able to obtain the views and perspectives of both professionals and service users.

4.2.2 Interview participants stage 3

Interviews were conducted with 23 interviewees, 17 professionals and 6 relatives of care home residents (see Chapter 2, paragraph 2.5.3). The majority of the interviews in stage 3 (N = 17/23: 13 women and 4 men) were recorded on audio-tape, with all data safely stored under the provisions of the Data Protection Act (1998). These interviews were analysed using Interpretation Phenomenological Analysis (IPA). The remaining interviews in stage 3 (N = 6/23) were conducted over the telephone and were not audio-taped. Documentation provided by the participants and field notes, made by the researchers during and after the interview, were also examined as a continuing part of the quality check on the research audit process.

Of the 23 people interviewed, 11 were from a PCT in the north of England (*Locality One*) and 12 people from a PCT in the south of England (*Locality Two*). In both locations, NHS staff also expressed willingness for members of the research team to return to conduct some more interviews with residents and their carers, in the care homes. However, members of the study team encountered some resistance from care home managers to the idea of interviewing residents, which may have been due to an initial suspicion, or uncertainty of the research purpose.

"Didn't you notice that they were not happy for you to talk to the residents? Please contact care homes direct and see if they will allow it.
{Location Two: telephone conversation with Community Liaison Nurse carrying out determinations with member of research team}

Care home managers did agree to give access to care homes shortly after the researcher's visit in location two, to enable the team to gain insight into the views of residents, their families and carers. However, only interviews with relatives were successful. These interviews (n = 5) were conducted over the telephone but not recorded on audio-tape. The interviewer's field notes for these interviews

were analysed for content (Robson, 1993; Denzin & Lincoln, 1998; Henwood, 1996; Gillham, 2000). The results from interviews with relatives are discussed separately in Section 4.4. Participants included:

- Three PCT co-ordinator/ lead nurses
- Two PCT nurse ‘assessors’ with the role of carrying out the determinations
- Two discharge nurses
- One PCT Administrator
- One PCT service manager nurse director
- Two care home managers
- Five care home nursing staff (matron, assistant Matron, sister, staff nurse & registered nurse)
- One PCT Finance Officer
- Six relatives of residents in care homes

A brief summary of all interview participants is shown in Tables 4.2 and 4.3

4.2.3 Method of analysis stage 3

A phenomenological approach (Interpretative Phenomenological Analysis [IPA], Smith, Jarman & Osborne, 1999) was adopted to analyse the audio-taped data. (n = 17), of which 16 were professionals and one a relative. Data from the interviewer’s notes from interviews with five care home residents’ relatives and one NHS professional, were extracted into tabular format and analysed for content (Robson, 1993; Denzin and Lincoln, 1998; Henwood, 1996; Gillham, 2000).

Preliminary themes were identified from the audio-taped interview data and these themes were then reviewed and / or modified in the light of additional data analysis with each successive reading and subsequent identification of themes and sub-themes (Smith, Jarman and Osborne, 1999). These preliminary themes were then ordered into emerging themes and connections before being developed into a master table of themes. Themes from the master list were then further searched for emergent themes and patterns, connections and contradictions. The master list of themes were then, in turn, examined for expressed emotions, tensions and juxtapositions. At this stage, the inter-relationships found between the emergent categories from the analysis were explored in depth. These connections and conflicts in the data were then incorporated into diagrams and flow charts, similar to the process of axial coding used in Grounded Theory (Strauss & Corbin, 1990). Themes that appeared to naturally belong together as a ‘cluster’ were then regrouped into super-ordinate categories and drawn together into a consolidated list. Any seeming tensions, or contradictions, among the categories that emerged during the analysis were examined and discussed amongst the researchers until reasonable consensus was achieved whilst, at the same time, remaining mindful of the interpretative methodology adopted.

Table 4. 2: Interview participants – *in depth interviews* (N = 17)

Participant	Male / female	Professional / user role	Location	Direct / indirect care	Date of interview	Audio taped Y/N
Interview 1	Female (<i>interviewee 1</i>)	PCT lead nurse co-ordinator	Location One	Indirect care	14 April 2003	Y
Interview 2 (<i>group interview</i>)	Female (<i>interviewee 1</i>)	Lead nurse co-ordinator 2 nd interview	Location One Team meeting: Older People	Indirect care	15 April 2003	Y
	Female (<i>interviewee 2</i>)	PCT Nurse ‘assessor’	Location One Team meeting: Older People	Indirect care	15 April 2003	Y
	Female (<i>interviewee 3</i>)	Discharge nurse	Location One Team meeting: Older People	Indirect care	15 April 2003	Y
	Female (<i>interviewee 4</i>)	Discharge nurse	Location One Team meeting Older People	Indirect care	15 April 2003	Y
	Male (<i>Interviewee 5</i>)	PCT nurse ‘assessor’ (mental health)	Location One Team meeting: Older People	Indirect care	15 April 2003	Y
Interview 3	Male (<i>Interviewee 6</i>)	1 st Care Home manager	Location One	Indirect care	15 April 2003	Y
Interview 4	Male (<i>Interviewee 7</i>)	1 st Care Home (carer – husband of resident)	Location One	Both care roles	15 April 2003	Y
Interview 5 (<i>group interview</i>)	Male (<i>Interviewee 8</i>)	2 nd Care Home (EMI) manager	Location One	Indirect care	15 April 2003	Y

Interview 5 (group interview)	Female (Interviewee 9)	2 nd Care Home (EMI) Care Home Sister	Location One	Direct care	15 April 2003	Y
	Female (Interviewee 10)	2 nd Care Home (EMI) Care Home Staff nurse	Location One	Direct care	15 April 2003	Y
	Female (Interviewee 11)	2 nd Care Home (EMI) Care Home RN	Location One	Direct care	15 April 2003	Y
	Male (Interviewee 5)	PCT nurse ‘assessor’ (mental health) 2 nd interview	Location One	Indirect care	15 April 2003	Y
Interview 6	Female (Interviewee 12)	RNCC Administrator in PCT	Location Two	Indirect care	18 April 2003	Y
Interview 7	Female (Interviewee 13)	3 rd Care Home Matron	Location Two	Both care roles	18 April 2003	Y
Interview 8	Female (Interviewee 14)	3 rd Care Home Assistant Matron	Location Two	Both care roles	18 April 2003	Y
Interview 9	Female (Interviewee 15)	Service Manager Nurse Director	Location Two	Indirect care	18 April 2003	Y
Interview 10	Female (Interviewee 16)	Lead nurse co-ordinator	Location Two	Indirect care	18 April 2003	Y
Interview 11	Female (Interviewee 17)	4 th Care Home Owner-Manager	Location Two	Indirect care	18 April 2003	N (drilling in background)

Table 4. 3: Interview participants brief telephone interviews, analysed for content (N = 6)

Participant	Male / female	Professional / user role	Location	Direct / indirect care	Date of interview	Audio taped Y/N
Interview 12	Female (<i>interviewee 18</i>)	PCT Finance Manager	Location two	Indirect care	15 May 2003	N (telephone)
Interview 13	Male (<i>interviewee 19</i>)	Son of care resident (Mother) 4 th care home	Location Two	Direct / indirect care	17 June 2003	N (telephone)
Interview 14	Female (<i>interviewee 20</i>)	Daughter of care home resident (Mother) 4 th care home	Location Two	Direct / indirect care	17 June 2003	N (telephone)
Interview 15	Female (<i>interviewee 21</i>)	Daughter of care home resident (Mother) 4 th care home	Location Two	Direct / indirect care	17 June 2003	N (telephone)
Interview 16	Female (<i>interviewee 22</i>)	Daughter of care home resident (Mother)	Location Two	Direct / indirect care	18 June 2003	N (telephone)
Interview 17	Male (<i>interviewee 23</i>)	Husband of care home resident (Wife)	Location Two	Direct / indirect care	18 June 2003	N (telephone)

The results of the thematic analysis of data from the in-depth interviews are summarised by super-ordinate category in Box 4.1. Diagrammatic 'mapping' was then used to further facilitate the identification of relationships between thematic groupings, resulting in a final diagram that summarises these results and their inter-connectivity (see Figure 4.1).

Figure 4.1

Super-ordinate themes and their inter-relationships - tensions & connections

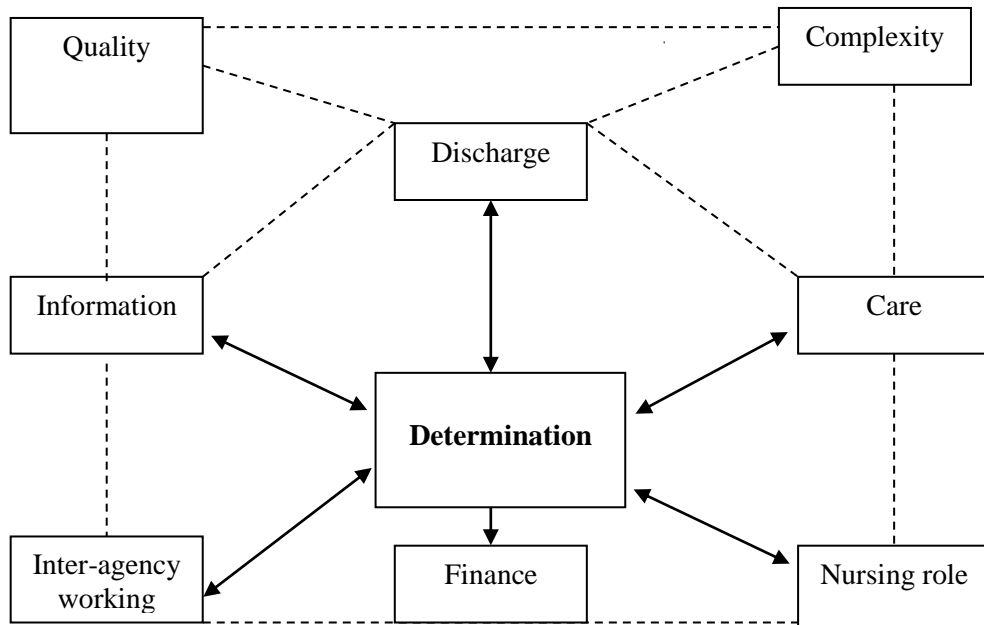
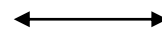
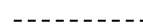


Figure 4.1 Key: Relationships between core categories are illustrated with arrows:



Axial coding links are illustrated using dashed lines:



Data from the five telephone interviews with relatives were coded for content and identified themes were then compared with the audio-taped interview data and mapped to the super-ordinate themes obtained from the IPA analysis (Box 4.1).

4.2.4 Super-ordinate categories

The interview data gave rise to a number of super-ordinate categories, containing both positive and negative elements. These were the categories of: *Determination*; *Care*; *Change and Complexity*; *Inter-agency working*; *Information*; *Finance*; *Quality* and *Communication*. These themes were not considered mutually exclusive, since shared linkages and cross-fertilisation were found, where some themes might belong to more than one category.

Box 4.1: Super-ordinate themes identified from in-depth interviews by strength of evidence

(N = 23)

1. **Determination:** Funding. Process of determination & time required. Relatives' & carers' care needs and concerns. Quality & consistency. Appeals process & banding decisions. Documentation, paperwork & administration. Continence & equipment.
2. **Care:** Quality of care. Mental health. Dementia, loss & bereavement. Learning disabilities. Issues around discharge. Respondents' voices. Working relationships. Nursing role & caring. Compassion.
3. **Change & Complexity:** Process of change. Uncertainty & doubt. Challenges. Stress, frustration, anxiety. Coping strategies. Perceived lack of transparency / clarity. Determination process. Funding.
4. **Inter-agency working:** Communication. Documentation & paperwork. Joint-working. Liaison with social care. Relationships with care homes. Working with PCTs and / or social services in other areas. Inter-professional relationships. Discharge issues. Links with hospitals.
5. **Information:** Inter-professional relationships. Discharge. Joint-working. Information & communication technologies (ICTs) & access to information. Information / help seeking. Documentation & paperwork. Quality of information.
6. **Finance issues:** Banding decisions. Allocation of resources. Funding of posts (e.g. in PCT). Uncertainty & doubt. Perceived lack of transparency of process. Acceptability to care homes. Improved 'cash flow'.
7. **Quality:** Determination process – how to assess quality. Quality of care & nursing quality e.g. continence training. Information and records. Quality of paperwork and documentation. Discharge process.
8. **Communication:** Inter-agency working. Liaison with social care. Misunderstandings. Different approaches. Advocacy. Lack of knowledge. Disempowerment. Communication with residents and their families / carers.

It was noticeable that, for both locations, analysis of these themes illustrated more similarities than dissimilarities. For example, in Box 4.1, the theme of *documentation and paperwork*, occurs in both super-ordinate categories of *Determination* and *Information* and is also linked to the categories relating to issues of *Quality* and *Inter-agency working*. Details of IPA and content analysis can be found in Annex 10 (Tables 4.4, 4.5 & 4.6).

4.3 RESULTS: PROFESSIONAL THEMES

Professional themes. Main findings were:

1. NHS professionals wanted more clarity about the RNCC determination process.
2. NHS professionals' *perceptions* were of the time they took in undertaking the determination process whilst learning to use the RNCC tool. They also acknowledged that the paperwork would probably take less time once they were more familiar with the determination process.
3. NHS professionals identified a need to formalise and 'protect' their reasons for banding determinations.
4. NHS professionals identified FNC benefit in improving care homes' documentation
5. Although RNCC had been introduced during a time of great re-organisation for NHS professionals, determinations had been successfully implemented.
6. NHS professionals reported that recommended guidelines about involvement of residents suffering from dementia were not always followed.
7. Some care homes adapted a paternalistic attitude leading to non-involvement of families and carers.
8. Care home professionals viewed RNCC as delivering 'fairer nursing' and a more flexible method of determining nursing need.
9. NHS professionals identified a need for leadership training and role definition guidance.
10. NHS professionals saw RNCC as a driver of inter-disciplinary working, but there were challenges to new ways of working and new models of care.
11. Increasing awareness in NHS staff training for valuing differences in professionals' care models in any joint-working initiatives could contribute to facilitation of attitude change.
12. NHS professionals viewed sharing of information as dependent on the ability to communicate electronically.
13. Care home professionals viewed RNCC financing process as acceptable, but expressed concerns about the lowest level of banding.

4.3.1 Determination

Discussion around the super-ordinate category of *Determination* focused on training for *FNC and the RNCC Tool*, *Determination process* including: *banding system* and *banding decisions*, and *FNC process-related attitudes*. As will be seen, trained RNs adopted other roles in the operationalising of FNC, e.g. acting as a caring resident advocate, a 'team player', and in management roles. This raises issues pertaining to the values held by participating organisations, professions and individuals, and provides evidence for the theoretical framework of values-based health care i.e. that, in order to provide good quality service and care, the conceptual emphasis in medicine needs to shift from a fact-based (medical) model towards a value-based (health care) model (Fulford, Dickenson & Murray, 2002).

(i) *Training for FNC and use of the RNCC tool*

During implementation in *locality one*, the RN identified for RNCC determinations was the key person trained via region in the use of the RNCC tool, and then a cascade system was evolved in the locality.

“The nurse who did the determinations went to region for training. We have a cascade training system. The district nurses all have training and we use the guide. They are all very experienced senior members of staff. They are all on G grades so they should be accountable for their practice.” {Locality One, lead nurse (CA)}

However, a lack of IT training emerged by the time of stage, 3 as an issue arising from FNC administration.

“We have not really accessed as much IT training as we would like, but that is one of our team objectives in the next couple of months now that the nurse assessors actually get some more IT training so they can use the systems and have some shared domains to deal with things but I haven’t had a lot of formal IT training, my secretary has just completed the computer driving license which has been a real benefit for us because she actually acts as our coach and nurturer or someone to come and troubleshoot when we have made a mess!” {Locality One, Acting FNC implementation lead nurse}.

In *locality two*, implementation training for senior NHS managers was provided from the DoH, and a similar cascade method of training for FNC determinations was adopted, from RN1 (first identified to undertake determinations) to the Acting FNC Implementation Co-ordinator, Service Manager, and thence to a cohort of other community nurses. However, when RN1 went off sick, the FNC trained community nurses did not pick up the training role. Instead, the replacement FNC RN (RN2) was trained by the Acting FNC Implementation Lead Nurse, Service Manager.

“We did, we actually train some of the district nurse care managers, the people that were care managers before ... district nurses, who have now gone totally back into their clinical roles. From the word go, our first nurse that went up to London and learnt how to use the RNCC tool, she came back and did some local training with about five district nurses. And then she passed on the training to me and I passed it on down to the [replacement] RN.” ... {Locality Two, Acting FNC implementation lead nurse}.

The Acting FNC Implementation Co-ordinator, Service Manager in *locality two*, also indicated that although an RMN had also undergone training for determinations by the DoH during implementation, his services were not deployed.

“.....we actually sent a CPN up to London with my nurse [RN1] to be trained on the RNCC tool. But in reality it didn’t happen that CPNs took over doing any of the determinations. Ideally we would have one, yes.” {Locality Two, Acting FNC implementation lead nurse}.

Following the implementation period, a cascade system for FNC training was in operation for the new RN intended to work alongside RN2, and by this time, there was the intended input from the newly appointed lead nurse.

“Originally a member of staff went up to London to train and it has since been cascade training. I was trained for RNCC by the previous lead nurse who had training at the old district level. I will train the new RN.” {Locality Two, Acting FNC implementation lead nurse}.

“I will do induction of new RN with [RN2].” {Locality Two, lead nurse}.

The actual determination process was perceived, by some of the participants, as sometimes quite time consuming, although they did acknowledge that the process was new to them and they were all recently in post. The changing balance in delivery of health and social care means that the roles of all professional groups involved in the provision of care are going through a process of readjustment. While these changes may usher in new ways of delivering care, they also challenge the roles and traditional working patterns of health professionals (Peckham and Exworthy, 2003). These drivers of change may then be perceived as a threat and go some way to explaining the uncertainty, tensions and contradictions identified in the data, linked to the super-ordinate category of *Change*.

(ii) Time needed for the determination process

The *time factor* was perceived by professionals implementing the new system as one of the problems that might be encountered when dealing with a challenging or complex case. This was a strong theme across both locations (locality one and locality two).

"I think in a way it could be a full-time job on its own, because of all the reviews and all the reassessments that have to be done. It's generally a full-time job. It's either a full-time job with good clerical help, with good secretarial help, or for nurses, as a part-time job, with full-time support. You know - either way would have to be looked at in that respect. But I think you always need a back up. I mean anybody could come in here (location) and (name) could give them their packs (determination paperwork) and they could go out and do the assessments. But the only problem is they haven't been trained." {Locality Two, Interview 10, interviewee 16. Lead nurse co-ordinator, (IPA) , Locality Two. 13:31-38}

"We're not quite sure, and I don't think probably anybody knows, quite what sort of input of time will be needed for free nursing care to keep it ticking over." {Locality Two, Acting FNC implementation lead nurse}.

"I suppose on reflection, when it first came in (i.e. determination process) [it meant] a lot more work, and it's just moving money around. And whilst I was actually grateful that, for once, a nurse was going to be involved [...] I thought that was a good move. My initial reaction was, where all the money was coming from and things. That seemed a bit complex really, and seemed to be making a lot of work out of something." {Locality One, Care home manager & nurse}.

Determination of more complex cases focused on the role of nurse as *advocate*, where the nurses using the RNCC tool, by nature of their professional training, would view each care home resident's case at the individual nursing level as requiring a compassionate nursing and problem solving approach. These issues connect to the themes of the *nursing role* and *caring* and *compassion*, contained in the super-ordinate category of *Care*.

Others emphasised the burden of associated paper work:

"There's a lot of paperwork that needs to be sorted out. And I'm trying my hardest to, sort of, try and get it onto there (computer system) so that we haven't got to sit down and write. I've got two hundred determinations to fill out for the Social Services people, so I'm trying to get it automated so that we don't have that hassle." {Locality Two, Administrator}.

(iii) Understanding the determination process.

A further observation concerned the use of the terms 'assessment' and 'determination'. For, despite the process being given as a 'determination of need for RN care' in the interview data, the word 'assessment' was more commonly used by interviewees including the nurses employed to carry out the determinations. Thus, from the interviewer perspective, it was sometimes difficult to distinguish *what type* of 'assessment' (or determination) was actually being referred to. On occasion, even the lead nurse and/or co-ordinators in the localities seemed a little bewildered, since the term 'assessment' may also refer to 'assessment of need', 'assessment for continuing care', or working toward 'SAP' (DoH, 2001 e).

"Our role has very much grown around the joint assessment, fitting in to the joint assessment, when the nursing care is the way - the route that's been identified for a robust review. Under the guidance (for determination of NHS funded nursing care) we have to do a 12 week review. There will be an expectation that, whoever is the assessor, they will actually meet with the social worker involved to do that first review."
{Locality One, team meeting care of older people, (IPA)}.

"The assessment is actually the nurse - looking at the nursing needs - and the unpredictability - the complex needs. Looking at if the patient is unstable and how many times a day, maybe an RN (registered nurse) would actually have to look after that patient." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

That professionals sometimes seemed a little unsure of these 'assessment' processes, due, no doubt, to the rapidly changing cultural environment in the change-over period from Health Authorities to PCTs, a point that was also reflected by the identified themes of *Change* and *Complexity*.

Interviewee 1: "We're, sort of, trailblazing in a way. And I don't think it's that hearts and minds need changing - they need supporting. [...] So actually, an assessment, something that acts as a trigger to the way, which way are we helping this person to go on the journey? Are the indicators that she can go back home [...] or are we looking at intermediate care? Because intermediate care's happening, but (I'm) not quite sure what they use as a guide? X (name)?" (asks colleague)

Interviewee 5: "No - I don't know." (shrugs her shoulders)

Int 1: "So yes, mm, with intermediate care, and that's a growing area."

Int 5: "We're pushing towards it, aren't we?"

Int 1: But there is a criteria for intermediate care."

Int 5: "Yes, but how do they actually operationalise it?"

Int 1: Well, it's any port in a storm. When they want a bed, the criteria goes by the book, doesn't it?"

Int 5: "That's right. So people are getting different experiences."

Interviewee 2: "Always been the way."

Int 1: "It's always been the way, and I was involved with setting up that and I know because I drew up the criteria, but the criteria was never used." [...]

Int 1: "We need a common pathway, that everyone, that you use the same documentation irrespective of where they're going" [...] You shouldn't have to keep going back and finding out the same piece of information not once or twice, but *repeatedly*."

(Team meeting - older people, Locality One).

Furthermore, the above data illustrate some of the contradictions professionals reported in their discussions around delivery of health care in a rapidly changing environment (the super-ordinate category of *Change*). Of note in the data here are the connections and tensions between the ideals of nursing and social care delivery and the reality of practice ("Well it's any port in a storm. When they want a bed, the criteria goes by the book."). It is also of note here, in this interview, how the participant draws support from her colleagues for her statement. She turns her answer into a question by the addition of the remark, posed as a rhetorical question, tacked on the end of the sentence, almost as an afterthought ("aren't we?" ; "don't they?"). This acknowledgement of the difficulties and tensions for staff in the provision of care is also reflected in the super-ordinate theme of *Care*.

The addition of review determinations and continence assessments also appeared to place NHS staff under pressure of time:

"At the moment it takes all their time just to do the reviews. We are trying to put extra assessments in for continence and so on, where necessary, so we do have services like continence, leg ulcers and so on, that can feed into nursing homes." {Locality Two, Acting FNC implementation lead nurse}.

Time was also needed for liaison with care home staff and in setting up meetings with family members and / or carers who wished to be involved, or consulted, in the determination process for their loved ones and often in complex circumstances:

"You have to try and pick a fine path, because you're never quite sure where the people - the relatives are [...] from the best interests (of the resident). Well - about this case, the daughter lives miles away in (city in the south west) and yet she has power of attorney. And the husband, who visits everyday, doesn't. And it's not as if he's losing his faculties. (*Mm, far from it*). The daughter hasn't seen her mother for months, yet she has power of attorney." {Locality One, 2nd care home (EMI) manager, (IPA) }.

(iv) *The RNCC banding process*

Professionals commented on the actual banding process of the RNCC determination tool. Much of their discussion focused on how the banding decision was far from being the detached, or 'objective', process suggested by the format of the documents that they were expected to complete (i.e. the RNCC determination tool, DoH 2001i). NHS professionals considered that the reality of carrying out a determination centred much more around a decision based both on what they identified as the nursing care needs for that individual, as well as taking account of their own accountability needs as professionals. As illustrated in the following comment, this sometimes required a talking it through with colleagues after they had visited a resident when a determination decision was not clear-cut. The discomfort of being in a position of either pleasing or disappointing relatives and/or the care home involved, is also evident as an example of the need to balance their clinical autonomy with professional and managerial accountability while adopting a team based approach (Degeling, Maxwell, Kennedy and Coyle, 2003). Some of these feelings may have been due to the process still being relatively new, but the data also identify nurses' concerns for their individual client,

as viewed from the nursing process model. The 'best' banding outcome in the context given below was perceived as awarding the highest banding level for nursing care.

"I think it (determination) has actually caused a lot more of the qualitative approach to the determination. If it was just a piece of paper that people are putting tick boxes in, like a scoring matrix, it is very impersonal, very detached from what you are seeing. Because when you actually go out to see someone it is not just written evidence from what someone else has collated, [...] it's about what you see and hear that brings it all together. And what the nurse assessors don't do is automatically make a judgement at the time, unless it is very clear. And then they come back and they either talk together or they will come in and see me, if it is someone on the cusp of one of the bandings. [...]we actually talk it through before any decision is made and shared sometimes. And then they are very clear about that, to the service user, if they are able to understand, or to their families. "You know, I can't make a decision today, I need to go away and reflect on this, and talk about it. There has been a lot of information that has come my attention". But within a day or so there is an outcome. We don't want to keep people dangling, that's unreasonable as well. Especially if they want to base their funding on that income, which, obviously, has been a worry too. People see the funding and the banding as permanent and what we've always said, "Oh well, if Mum or Dad improve, this (i.e. funding) could be reduced. And the care homes see that we do well for someone and then we are depriving them if the money reduces." (Locality One, Acting FNC implementation lead nurse (IPA)).

Some NHS professionals questioned the economic efficiency of using a banding process to determine RN care needs.

"I would say, my personal view is, that the actual money that we're giving to people is a pittance really. [...] I mean, why, from the word go, mind you it's too simple to sit here [...] Why didn't they just pay everybody in nursing homes at medium band and forget all this?" {Locality 2, Acting FNC Implementation Lead Nurse, (IPA)}.

Whereas, others showed evidence of reassessing their role in relation to the care needs of independent sector residents that could be met by community nurses.

"The district nurses were only tending to actually give the care that was needed. What they weren't having the time to, or weren't doing, was the supervisory, or monitoring, aspect of the care plans. So they'd come in and do a dressing, but they weren't actually coming in and reviewing to see if whatever they did was preventing. It was only when they (care home resident) developed a pressure sore that they ended up coming in. Which, to me, was - that's not *nursing* - you know? We should be preventative, not reactive." {Location one, 1st Care home manager, a qualified nurse RN. (IPA)}.

Of importance in attaining equality and access to services in keeping with the National Framework for older People (DoH 2001 b), the determination process for EMI residents within the FNC system, appeared less consistent than for other types of residents. For in *locality two*, it was acknowledged that there was no regular involvement of an RMN/CPN in determinations:

"She [RN 2] does [*undertakes EMI determinations*]. Although, we do have a CPN. We have had problems, I mean with our mental health CPNs. Our service is really, really stretched, and we have had problems in having consistency over the support from CPNs. But we've got someone now, and she will help. [RN 2] tends to do them and then talk over the results. A home like ...that you are going to go in, does have CPN support. I mean the chap that runs it is RMN. So to a certain extent I think [RN 2] did her determinations using him and his views of how much this patient could be expected to do. {Locality Two, Acting FNC implementation co-ordinator, service manager (IPA) }

“It is feasible that only RNs carry out the determinations but we do sometimes use an RMN to help with determinations” {Locality Two, Lead nurse (IPA)}.

(v) RNCC tool adaptation and documentation

At the same time, the data show that some professionals considered that in practice, there was a need to "adapt" the RNCC tool. 'Adaptation' usually meant, in this context, additional material being written (usually by nursing team members) and added to the determination documentation. Evidence for this was found in both locations. In particular, some nurses wished to document their decisions by providing evidence to formalise and 'protect' their reasons for banding decisions.

“What we set up – we use basically what is in the workbook which is obviously very simple. And that has been adapted slightly. Because we felt, for demonstrating for how we have collated that information we have set up a procedural check list which was partly an *aide memoir* so that the nurse assessors were working with some consistency: they were following a pathway, otherwise they would end up doing different models. And, because I am bringing on two community liaison staff from the hospital as well, for me, I want to see that one pathway is followed. [...] otherwise it could all go off at a tangent - doing their own thing.” {Locality One, Lead nurse (IPA)}.

In locations where the determination tool was found to have been 'adapted' and / or extended, nurses carrying out determinations were endorsing these decisions to present a "watertight case". In *location one*, in some instances, banding decision was endorsed by the inclusion of professionals' signatures against their annotations on the documentation. NHS professionals considered this to be necessary in case of any future challenge of a formal nature (i.e. appeals) by care home residents' families who might be unhappy with the banding decision. By adopting a defensive approach, documenting the reasoning behind all determination banding decisions in detail, while commendable for being thorough, would obviously contribute to the time needed for the documentation process.

Some NHS professionals also acknowledged that, due to time restraints, they were heavily reliant on residents' records and their care plans held in the care homes. In some cases it was also rather unclear whether the resident's family or carer had been consulted, or even notified or informed that they could be involved with the determination of their relative's nursing care banding decision.

“I usually sit down with (*name of nurse carrying out determination*) and we go through the notes. We usually agree. [...] Residents aren't involved as they would not understand and it might confuse them. We do tell relative about determinations but they do not choose to be involved.” {Locality Two, Care home owner-manager, 4th care home (IPA)}.

This is a complex issue, especially for people suffering with dementia and related mental health problems, as evidenced by the interview extract below from a Care Home Assistant Matron.

Assistant matron: “Most of the residents are rather muddled mentally, you know”.
Researcher: “So they wouldn't remember when they had determinations? Because they

weren't involved in that?"

"No, they weren't involved. They were never informed. None of them [...] with me (i.e. in care home) have been involved in it really, because they just weren't capable of realising what's going on really. It'd probably worry them more than anything, you know?"

"Are the relatives ever involved?"

"They can be, but not the ones I've done, no. Nobody's ever actually been here during the assessment. {Locality Two, Assistant matron, 3rd care home, (IPA)}.

Of importance in the above comments, is the rather paternalistic attitude expressed through this care home's adoption of a policy of non-involvement with families and carers. Although it is easy to see how this might be the easiest decision for a busy and over-stretched care home to take, once again, this highlights the difference between the reality and the ideals of providing care.

However, on a more positive note, the actual use of care home records in the determination process was viewed as beneficial by some professionals since they perceived that, as a consequence of FNC, residents' records were of a consistently higher quality than may have been found previously. NHS professionals pointed out that the value of good record keeping was that it enabled them to carry out their determinations more proficiently. Time given to the updating of records was considered to be time well spent and had the potential to reap benefits for future determinations. It was also thought to enhance good practice in the delivery of care. Good record keeping was also considered helpful for efficiency of audit and to establish consistency of procedure.

"And that has to be consistent and it has to be robust, otherwise it could all go off at a tangent, doing their own thing. I know that people in my position, in other areas, have had this to deal with, but we also set up a procedural check list which helps to audit what we do. It also helps, certainly around continence audit, about equipment, and also looking at, perhaps, gaps in service provided from the PCT. So that is how that was set up. It also gives scope to add further information, because, as you can imagine, some things that you can't share with the service user, or the carer, but we need to keep on file for future reviews if a different nurse assessor went. You know it's about making choices. " {Locality One, Lead nurse co-ordinator, (IPA)}.

However, the excerpt from the above comment, "as you can imagine, some things you can't share with the service user, or the carer, but we need to keep on file", further possibly indicates the element of paternalism, or subscription to an (over) protective model of care.

(vi) Resident and relatives involvement in determination

Professionals were also highly aware of families', relatives' and carers' concerns around the financial considerations. Families were perceived as wanting the 'best' care for their parent or older relative and sometimes did not understand, or take kindly to, the banding decision outcome. In *location one* the roll out of RNCC and recent publicity in the national press (Abraham, 2003), had thrust the professionals into the public gaze, at the same time as they were implementing a new process.

“It has been a very complex bureaucratic system to roll out. If we don’t understand it, if professionals can’t understand it, then the service user and their carers don’t stand a chance, do they?” {Locality 1, Lead nurse co-ordinator (IPA)}.

Where relatives *had* been involved in the determination process and banding decision, it was not necessarily easy for the family to accept the decision, especially for a spouse who might also be older, or in a frail state of health.

"I was still disappointed when I found out I couldn't look after her any more. You know, I never wanted her to come into a nursing home. [...] to me it's illogical (banding levels). You see it's logical to have them, but how do you, how do you impose a sliding scale? [...] If you ask me honestly I would say that £70 is better than a poke in the eye, can you understand? But I still feel as if I've been poked in the eye!" {Locality One, (Carer - husband of resident with Alzheimer's disease, (IPA)) banded on middle band £70.

This above examples display obvious links and connections to a *value-based* nursing care approach (see section 4.3.1).

Communicating with people with dementia, or other mental health problems, is also a complex issue. It has practical, moral and ethical implications, both for communication in care (Killick and Allan, 2001) and the actual determination process. The issue of not involving family and carers in the banding decision probably needs further examination and clarification. It would appear, from some of the data in this study, that the recommended guidelines for involving people with mental health problems, such as dementia, in their own healthcare decisions are not always followed (Department of Health, 1999, *NSF for Mental Health*). This links to *relatives' and carers' needs*.

(vii) Resident's nursing needs

However, implementation of RNCC had highlighted some care home residents in *location one* who, since their original health need for entering a care home, may not have been in receipt of optimal levels of care appropriate for their on-going or current needs. In location two, examples were cited of care home residents who had “slipped through the net” and had been omitted from having their nursing care needs determined.

Interviewer: “What were the sort of reasons why you think they’ve dropped through the net?”

Interviewee: “We really have no idea, but there was one lady that, suddenly, a residential care home came up with, that nobody knew was there! And she was one that needed to be assessed. But, when we thought we’d done all the self-funders, one other self-funding one came up and ended up having to have nine months back pay because she didn’t turn up. [...] apart from nurses going round and walking round going “Have you got any other rooms in here? Are you hiding anyone?” [...] Or maybe someone was in hospital at the time? She wasn’t there when they did the assessment, they forgot to tell (us). You know, there could be a number of reasons.” {Locality Two, Acting FNC implementation lead nurse}.

These cases were the subject of much debate and frequently the focus of “off the record” discussion, especially in *location one*. These tended to be the cases that the nursing teams would discuss in the interviews as having been a focus of some distress. However, implementation of the new system did, in fact, lead to a review of these residents and thus the design and delivery of a new 'package' of care that was more appropriate for their current health and psycho-social needs. The extract from the data in Box 4.2, illustrates one such case. The themes of *Quality of care*, *advocacy* and *compassion* and stress are also illustrated.

Box 4.2 Example from the data - illustration of themes contained in determination process

“...and from some of the quite distressing scenarios, because these people tend to fall into, you know, who advocates for them?

One of the distressing things we have found, and, as a team, we have perhaps supported people a lot, is people who have been forgotten. And some of those people are younger people who have been placed in a nursing care home and have had the first case review and then – “case closed”. Then funded nursing care has come along to actually review them as part of the preparation for the first of April this year. We couldn’t band them for nursing care needs because they didn’t require it and they have lived in some of those facilities (i.e. care homes) for a long time. And one young man was 36 and there was a lady of 40. One had been in the system for quite a number of years and should have been having a care programme approach under the Mental Health Guardianship, and that hadn’t happened.

And the other lady - very complex situation - but she had been diagnosed as having a terminal illness and then had obviously stabilised and amazingly the case had been closed.[...] But she was living her life, or may still be living her life, in a nursing home set up with generally much older people around her. She still has needs but those needs could be provided in a much more open facility and she could be in sheltered accommodation. [...] So to our amazement the case had been closed and we had to question why – but as a learning scenario for everyone involved. [...] It had obviously been a very, very distressing situation. [...]

(Locality One Lead nurse co-ordinator).

The ongoing discussion among NHS professionals around these concerns of residents’ nursing needs, emphasise two of the other categories contained in the data: *Communication* and *Inter-agency working*. Connections and contradictions were explored, for both locations, in relation to these themes as the following data extracts illustrate.

“She’s funded by Social Services, but she’s paid by district nursing. [...] The district nurses were finding it very difficult to do the dual role because they were being torn between urgent clinical work and care management work. So it really didn’t work quite how we expected it to. So we put all our eggs in one basket, with (name) and although she’s one of our staff, she sits at Social Services and Social Services 'back fill' her, if you like, into district nursing. So, although she’s paid for by Social Services, she’s very much a district nurse.[Yes] And her input within Social Services has been really valuable [...] and she has access to all the information. [...] so really it’s worked very well because they’ve kept her informed of all the patients and we’ve been able to work through.” {Locality Two, Acting FNC implementation lead nurse}.

“They were placed at our former – it was a private hospital – because there was nowhere else for them to go to. One would suspect that residential care is their only option at present, isn’t it [...] but from time to time, but, because of their transient symptoms, they will need nursing. [...] It’s difficult to know what’s needed, if you like. And for years they’ve just been given the minimum - they didn’t have the nursing care

they need. But probably with another social package, or a social-psychological package they could manage (in the community).” {Locality One, Care Home (EMI) Manager (IPA)}.

Thus, tensions and contradictions for the super-ordinate category of *Determination* centred round the nursing role, advocacy, the determination process and ‘fairness’ to all, the classic contradiction of an ‘individual’ identity versus a person’s ‘professional’ identity in the community or organisation. In the data, tensions were identified round a nurse’s commitment to acting as an advocate for his/her patient (i.e. a resident in a care home) set against the determination role and the ‘assessment’ of the nursing care need (level of banding) at the PCT level. This data extract also illustrates the shared linkage to the theme of *joint working and liaison with social care* contained in the super-ordinate category of *Inter-agency working* (see section 4.3.4).

The point needs to be made here that the RNCC tool was designed and intended to be used as a determination of nursing care need, *not* an assessment. The original idea was that the single assessment process (SAP) would feed into, but not substitute for, RNCC determination of nursing care need, although the introduction of SAP was delayed. Findings from stage 3, provided by this sample of participants, suggest that this distinction needs further elucidation. This has been confirmed subsequently through day to day work with nurses undertaking these roles. This theme was also one of the conclusions drawn by the Health Ombudsman’s Second Report into nursing care funding (Abraham, 2003). The same need for clarity was also an issue in participants’ discussions around the identified themes of *Inter-agency working* and *Communication*, due to the cultural differences between health and social care.

(viii) Determination: Conclusions

In conclusion, the tensions and contradictions for the super-ordinate category of *Determination* centred round the nursing role, advocacy, the determination process and a desire for ‘fairness’ to all – the classic contradiction of an ‘individual’ identity versus a person’s ‘professional’ identity in the community or organisation. In the data, tensions were identified round a nurse’s commitment to acting as an advocate for his/her patient (e.g. a resident in a care home), as required by the NMC, set against the determination role and the ‘assessment’ of the nursing care need (level of banding) at the PCT level. The determination process was expressed as having positive and negative impact. It was considered an enormous challenge, and even an exhilarating experience but for the nursing staff involved, issues relating to what was uncovered during the determinations could take considerable time and effort to sort out. Part of this time factor was viewed as being due to the professionals’ perceptions of the length of time they took in undertaking the determination process while they were learning to use the RNCC tool in the field. This time factor in relation to the determination process needs to be highlighted. Professionals acknowledged that the paperwork would probably take them less time once they were more familiar with the determination process

4.3.2 Care

Much of the current health care policy emphasis in the UK is on raising care standards, especially standards for older people, for example with the *NSF for Older People* (Dept. of Health, 2001). The reconfiguring of services and funding, over the past few years, with the call for health services working in greater partnership with Social Services has led to attempts at a much more 'joined up' approach of collaboration and joint working (see for example *Working in Partnership*, DoH 1999).

The impact of FNC related to the theme of *care* encompasses the concept of *respondents' voices*, where participants wished to get their message across as to how they felt as workers 'in the field', and about their vision for the future of care for older people. Some staff were driven by personal motivation, having experienced the 'system' with a loved one. In general, the staff showed compassion and commitment, making them a valuable, care resource who had been enriched by their personal experiences, as illustrated in this comment.

"I would like to see a proactive approach into preventing permanent placement in residential settings in the first instance.[...] I think it's a very, very sensitive time and I've lived through it personally with my father-in-law and perhaps I'm a bit more passionate about it but I think that passion is rightfully placed. [...] We think "Could have done it differently?" For me, it's about helping to advocate for people that you can live with your decisions. You know? Because you do carry guilt, you do carry questions in your mind" {Locality One, Lead Nurse (IPA)}.

(i) *Quality of care*

Sharing of 'best practice' is one of the visions for the provision of good quality care, especially for those people with complex health and social care needs such as older people, and has obvious links to a *value-based care* approach. How this care is delivered also has links with *different models of care*, due to the different professional groups involved:

"There is person centred care and there is sensitivity to people, that it (residential care home) becomes their home and quite a lot of the value base for a lot of the homes is just that, you know? People come to live in here and this becomes their home. Even though their home has shrunk to one room with, hopefully, a loo and a sink to call their own - that's the way they train their staff and we can actually see that in the way they deliver their care in that value base which is reassuring." {Locality One, Lead nurse co-ordinator (IPA)}.

RNCC determination was also perceived, from a care home perspective, as providing a means for the delivery of care that was relevant to residents' needs. It was often referred to as 'fairer nursing':

"For once those residents were getting the care they should have been getting and that they were being acknowledged as having needs that previously hadn't been addressed. And I think that's been one of the best moves of the fairer nursing system personally." {Locality One, Care home manager (IPA)}.

However data from both locations, showed that, in reality, how 'best practice' was communicated and delivered was challenging to the professionals working in the field, especially in relation to the

determination process. In location two staff were concerned that time spent on the determination process took them away from monitoring quality in care.

"We haven't been able to [...] actually be monitoring the quality of work that's going into nursing homes. And that's actually where we need them, not doing determinations - we've done that bit. Let's say they all get (*X amount of money*) they all get whatever, and then we concentrate on going in and making sure the nursing care's right." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

There was evidence of good practice being delivered by 'pockets' in small teams and they seemed to be dependent on individuals with a vision for the future. These professionals were actively engaged in thinking up ways to involve other professional groups to develop and maximise the opportunities to work flexibly across organisational and professional boundaries set within the framework of using the RNCC determination process. Staff in *location one* appeared to have made further progress with this than was evident from the data in *location two*.

"We've not really had robust review systems [...] They've left a lot to be desired - let's put it that way. Though we feel, by starting joint working with Social Service colleagues, by bringing people together, perhaps with the NSF banner of 'person centred care' for older people - but actually extending it for any adult who is going to come through that system - and come by us for registered nurse determination. We can at least influence more choice, and obviously offer a more objective support for them to make these decisions in. Perhaps a more reflective way than, you know, six weeks after - Mum's in hospital and all sorts going on. It isn't a long time really to make a big life change is it? Sell your home or give up your council house or whatever - and many people do that and they've nowhere to go then. That is it. Their home has gone so that they have to stay in institutionalised care because they've made that decision." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

In *location two* staff were aware, however, that they needed to work further on changing current practice and were also working towards this objective.

"We don't always know what happens to patients. [...] We still meet in the city, really, we're going to just keep meeting until the Social Services bit is all sorted, because it's still a bit of a minefield. And I guess, until we've managed to bring both of the, all of the, payment systems under one umbrella, I would think it would pay to keep meeting. [...] I think if you can base people together joint working just happens." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

"Obviously this (determination process) has only just been set up within the last year hasn't it? You know, the whole idea - and it's sort of been a gradual awareness of what's actually going on. It's been very interesting to get involved with it. [...] And so it's been sort of, "Well, let's try this, let's do that, let's see what information - it's finding out what information people need, and what they find of interest and value." {Locality Two, Administrator (IPA)}.

(ii) Impact of the determination process on care

NHS professionals saw that RNCC demonstrated the possibility of a more flexible approach for the delivery of healthcare. This was viewed as having a positive impact on care from the care home perspective and made RNCC acceptable to staff. Having an independent RN to assess residents' nursing needs was perceived as reducing bias, since care homes charge fees and so cannot be viewed as detached

in such determinations. For, as one care home manager in *locality one*, a qualified nurse, pointed out, because he ran a business, his views were sometimes seen as being based on financial needs when it came to decisions around nursing care needs for a resident. This had caused problems with the previous system, especially in relation to Social Services:

"It didn't matter how well I tried to make the case to social workers, they had a strict criteria, so, unfortunately, that is what they were stuck with. So the fairer nursing actually gave me an independent nurse to come in and make an assessment. [...] Because you are seen to have a slightly biased viewpoint, no-one would really take any notice of your professional opinion. [...] I think what they thought was that, well, it meant more money. So I could say what I liked to get more money! And I, I actually found that quite derogatory about my professionalism really. And so it was really nice to have an independent nurse [...] who would come in" {Locality One, Care home manager - a qualified nurse (IPA)}.

In contrast, in *location two*, the view of NHS staff involved with RNCC was that care homes had not been, to begin with, quite as co-operative as they could have wished. The problem, as they saw it, stemmed from financial issues for the care homes, which they were resolving by negotiation at the PCT level, using local budgets.

"One of the big issues for us, in the city, is that the nursing homes haven't really played ball. The reason why is really because they feel they haven't been funded to do the extra work that's been (involved). I mean - I expect you've heard this - not a new story I'm sure? [...] But the clinical or clerical support to nursing homes was an issue. [...] We said that we were prepared to give some money to nursing homes to help them out with this." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

From the care home perspective, these financial issues were causing some problems, especially in relation to those residents whose care was being funded by local authorities (as opposed to 'self funders'). One advantage of RNCC from a care home perspective, was found in the possibility of accessing appropriate equipment for their residents in a timely and systematic way.

So how has this new determination process affected you as a care home manager?

I think it's really nice actually, I mean, I'm very lucky, I have worked in other homes where it's very difficult to get equipment and, sort of, get funding really. [...]

With this system now (RNCC determination), I mean, it's so nice, because you just have to pick up the phone and C (name of nurse determinator) comes out and assesses them. And you know, we get it.

Whereas, you know, sometimes you're really battling with proprietors that say, you know "I haven't got the money to fund that" You know? And it's very difficult, if you're trying to meet the needs of a patient."

{Locality Two, 3rd care home manager (IPA)}.

(iii) Leadership

NHS professionals engaged in introducing RNCC at the PCT level, identified their need for *leadership* skills in order to best manage other professionals, such as nursing colleagues, and to lead their teams. In *locality one* the lead nurse /co-ordinator had been able to attend a course on leadership, funded by the PCT. However the training material, while having a nursing focus, was based on material from almost

ten years ago and referred to research literature dating from 1994/5. The training manual was also based on an American model of healthcare delivery rather than adopting an approach for UK or European care systems (LEO course: *Leading an Empowered Organisation*, Miller and Smith). Leadership in the NHS and public sector is a rapidly developing field with a large body of literature (Performance and Innovation Unit, 2001; Degeling et al., 2003). While it is useful to develop leadership skills at a PCT level, the training provided, while a beginning, might be considered insufficient to optimise and support the development of nurses and related clinical staff, as managers.

It was also of note that, in both localities, the overall management of the process for determination of NHS funded nursing care appeared heavily reliant on just one individual. In both PCTs this was the lead nurse co-ordinator. Across both locations these professionals carried out their work diligently and professionally and showed high levels of commitment. They exhibited high levels of energy in attempting to make the determination process 'workable' in the targeted time. However, it was also apparent that, for both localities, the determination process appeared over reliant on a single RN undertaking determination, and this could have inhibited the growth of a professional team approach.

"I think it will be even better when there are two nurses that can do it (i.e. determination). Although I know the guidelines actually prefer (to have) a number of different, to have a number of nurses doing the determination don't they? But I think while we've got the person we've got here, who's very reliable and doesn't go off sick a lot and so on, I think (having one person) has worked for us. We do have others (nurses) that have been trained to do it, but we prefer not to use them. [...]
We always felt it was better to have one person doing it, because of having the same approach. [...]
And if you, at least, have one person doing it you know that everybody's being treated fairly."
{Locality Two, Acting FNC implementation lead nurse (IPA

For any leadership model to be effective in the long term, the designated leader needs to be supported by a team committed to the same aims for the successful maintenance, or completion, of any project (in this instance the adoption of the determination process) (Spurgeon, 1999). It is a point of some concern that these lead nurse/ co-ordinators appear to be carrying a heavy burden of work. Without proper levels of support at an organisational level, they run the risk of stress which may lead to future ill health and burnout (Arnold, Cooper and Robertson, 1998).

The data illustrate that the co-ordinator/ lead nurses were already working very hard and were approaching, or had already reached, their working limits. In both PCTs one person was perceived as possessing the 'expertise' in relation to the organisational knowledge of the determination process. This role was, in both locations, taken by the lead nurse/ co-ordinators who were busy acquiring the different skills they had identified they needed in their position. There did not seem to be any extra capacity built in to the determination process that would allow for leaders' absences or additional tasks traditionally outside nursing. In such a situation one has to question how these systems would fare over the long term.

Interviewer: So you are doing finance as well? (following discussion about financial issues)

Well I am trying not to! I am not a trained accountant. I keep saying "I am only a nurse". I mean they are very good, but again, our Finance Department - this is just one of the plates they are spinning basically. I think there is an awful lot going on. We inherited debt from the former systems and we are actually having to go into brokerage with the Strategic Health Authority which I am sure is the biggest headache for our Director of Finance and our Chief Executive. [...]

I report to the Director for Clinical Services Directorate and we have been championing this at management team level - then everyone went "Oh gosh! There's all this to do!" [...]

It's not as if there isn't a willingness to work together but, obviously at Director level, and all the way through, we have to protect our own budget allocation. [...]

They (i.e. the nursing staff) are accountable for their own work and any omissions they make but, as Head of the Service, the buck stops with me."

{Locality One, Lead Nurse (IPA)}.

In both locations the leaders were working towards building their team for the delivery of care for older adults and the implementation of RNCC but, due to organisational changes and pressures of work, the formation of their teams had been slow to get off the ground. Indeed in *location 1*, the team responsible for older adults had finally managed to meet at the time of these interviews (April 2003) at the conclusion of their first round of RNCC in their area.

"This is an open meeting and it's the first time that we've actually met. It's a pity that (name) is off, but that's life isn't it? [...] It's good to have you all on board and you know, I think your experience and your input will be very valuable." {Locality One, opening remarks by Lead nurse co-ordinator at team meeting care for older adults (IPA)}.

In *location 2* staff acknowledged that further work was needed if they were to change their models of care to accommodate changes in care delivery and achieve their targets.

"We are probably behind some people in this. I must say, we haven't moved as quickly as perhaps we should have done. We've had our first set of workshops with clinicians, social services - multidisciplinary workshops really - and getting people to sit around and talk about it how, you know, their feelings around assessments. [...] It's not really about pieces of paper - it's about change. [...] we actually need some dedicated time. Again, I think it's a government (matter), it's like all the NSF's - they're all good, but in practical terms they're not easy to deliver. It's a nightmare." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

However, trying to change patterns of working and integrate professionals' differing models of care in working flexibly across professional boundaries was considered both complex and challenging, showing evidence of linkage with the theme of *complexity*:

"It's about looking at it in a cyclic way isn't it really?" {Locality One, Lead nurse co-ordinator (IPA)}.

The data illustrate the tensions that arise in the dual processes of changing working patterns and integrating different models of care. Interviewees, in both locations, considered that learning was an on-going process, as shown by the following extract from a team meeting of professionals providing care for older people across a locality:

"We take on board comments and other ideas because, as I said to you before, we are still learning, we're constantly learning - evolving roles as to the job we must do [...] nursing guidelines, but also it fits into the bigger picture, the little things that are going on. Which gives us a constant challenge. Because there is so much going on - in parallel to *so* many things. And the poor patient and the family are in the middle of all of this, trying to make sense of it, when sometimes we can't make sense of it! And, hopefully, you know, one of our priorities is to keep the service person-centred, which I think, you know, we do achieve." {Locality Two, Group interview - older people team meeting (IPA)}.

"It is building a brick at a time [...] a bite sized chunk that we can manage [...] We're actually effecting some change." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

This example illustrates how, in the call to modernise service delivery, professionals have to reach an acceptance that their clinical decisions may have a resource implication at PCT level. This may be perceived as a challenge where they struggle to balance their clinical, nursing needs against their organisational accountability (Degeling et al, 2003). It is also of note here, that there is an acknowledgement of residents' and carers' needs, the nurse as *advocate* in relation to the nursing role and caring with the aim of a compassionate approach ("keep the service person-centred").

(iv) Issues around discharge and inter-agency working

NHS professionals also discussed issues relating to the *quality* of care and *change*, especially in relation to the *discharge process* (Vetter, 2003). This was sometimes found to be rather problematic, especially in relation to *inter-agency working*. There was evidence here of shared linkages and cross-fertilisation found in the data analysis, where themes might belong to more than one category.

"Our community liaison service was actually pruned down under a previous management decision making process which might have been a good decision at the time [...] but was actually a very unhelpful decision. [...] I think the team need to grow to adopt a very much more dynamic role [...] to make sure Mrs So and So has got a bed before she goes home (i.e. discharge). [...] It's a very complex journey and we hope that will get better. We think that is really the emphasis in the job description now isn't it - to look at the more complex discharge." {Locality One, group interview. Services for older adults team (IPA)}.

Professionals considered that the success of the discharge process depended on the individual concerned and were reliant on the establishment, and maintenance, of good working relationships:

"we used to have a Liaison Nurse who worked just within Older Services. And she was absolutely superb [...] so that we would actually have very good liaison and very good discharges. And once that person was pulled away, you could immediately see the quality of the discharge. And it was absolutely fraught with problems." {Locality One, group interview. Services for older adults team (IPA)}.

Another theme to emerge focused on the issue of professionals providing appropriate care. Again, much of the discussion centred round issues relating to the use of the RNCC determination tool, and on what banding decisions might mean in practice for different professional groups. This was especially the case with cross-disciplinary groups such as mental health care provision and focused on working relationships and team building.

"many of those we end up supporting now are those with enduring mental health and physical problems. They are quite often more distressing, difficult, you know, to support. [...] We hope that everything we do now we can involve the Mental Health Team. We had a very positive workshop, didn't we, a month ago, on some assessment process and criteria and they are waiting for more basically." {Locality One, group interview. Services for older adults team (IPA)}.

(v) *Working relationships and inter-agency working*

Interviewees identified that the success of the RNCC was very much driven by the need for having, and developing, teams and good professional relationships, both with other health and social care professionals within the PCT and with the care home staff and managers.

"And we actually think the whole free nursing care issue (i.e. RNCC determination) so much overlaps with other things that it made sense to us to try and link it in anyway with Social Services, with continuing care, with hospital discharge. So that's it, that's the way we're developing it here in the city [...] with a team approach. [...] So we're an evolving service, I think, in the city." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

4.3.3 Change and complexity

The concept of change emerged strongly in the analysis. Staff perceived it as both a challenge and a barrier to provide quality care due to the complexity of the system they were learning to implement, alongside the organisational changes in the move towards PCTs. Staff wrestled with these issues and found it stressful and exhilarating in equal measure. Some of the perceived stressors were the process of change itself and feelings of uncertainty and doubt engendered by the changes. Many professionals, as they talked through some of the issues they had already encountered, could see the rationale for the new process, although they sometimes felt they were having a somewhat 'bumpy ride'

"There was a lot of changes going on as well. So total lack of continuity. Very stressful indeed, yes. So we sort of felt that we've ended up as care managing and nurturing and supporting quite a lot of people until we've obviously had to move the case back into the social services arena. [...] Accountability is, that is where she is at this moment. But what would have happened if funded nursing care hadn't have happened and progressed – that lady would still be sitting there!." {Locality One, lead nurse co-ordinator (IPA)}.

Implementing FNC while coping with the (perceived) complexity of the process had led to staff feeling that there was too much to achieve in too short a time frame. At the same time professionals voiced the opinion that there was a *perceived lack of transparency* and / or clarity. This contributed to their feelings of unease as they coped with the challenge of the new process.

"So the time frame suggestions from the first set of guidelines that came out were that the determination should only take – I think they quoted about half an hour or something. [...] Very unrealistic. Yes, very unrealistic. I mean we strive to work to Best Value and the nurse assessors won't go to one home unless they have to [...] So they've packed in about five or six at a time, in a morning or an afternoon and they come back to write up the documentation but you only need some very concerned relatives, or some challenging relatives and it could be one – one and a half hours sometimes with one person. [...] You end up working as a care manager really." {Locality One, lead nurse co-ordinator (IPA)}.

These feelings led to the theme of *respondents' voices* where NHS professionals wished to get their message across as to how they felt as workers 'in the field', and about their vision for the future of care for older people.

In *locality one*, at the time of implementation of FNC, there was a project lead and a relief RN supported by finance manager at HA level. The HA held a stakeholders meeting with providers where it was agreed to pay the latter at middle banding (£85) for each self funding resident and adjust any deficits following the self funding determination round. The lead nurse/co-ordinator was not appointed until March 2002. Reasons for the initial structure appeared to have been opportunistic due to pressure of time and availability of staff.

“Although we only had a relief trained nurse (previously hospital bed manager) who was trained at region, in charge of doing the determinations, there was good project management support. It all had to be set up rather speedily. In some ways the implementation of RNCC has been a very complex process to actually operationalise and as professionals we have struggled to understand the guidance and the complexities of it and the impact and of the service delivery and then keeping the recipients of the funding and their carers and meaningful people focused on it has not been easy.” {Locality Two, Lead nurse/co-ordinator. (IPA)}.

By the time of the stage 3 interviews in May 2003, the structure of the roles involved with FNC had changed to include the involvement of more staff in *locality one*.

“We have a nursing team in place for funded Nursing care” {Locality One, Lead nurse co-ordinator (IPA)}.

The initial RN doing determinations had left the NHS and a lead nurse/ nursing home co-ordinator (joint appointment) was in post. Although held by an RN, this post included responsibility for the budgetary issues related to FNC and with a direct liaison to a finance manager. This lead was also responsible for management and training of RN's for FNC. An administrator was appointed and links with social services were being established.

“I was allowed autonomy, supported in strategy development and have an identified budget for training and staff development. We identified the need for admin support and a support officer was appointed in July 2002. She has been invaluable in setting up a data base of self funding residents and our time table of determinations and outcomes. We have a lot of different IT software and are working towards linking with social services data bases.” {Locality One, Lead nurse co-ordinator (CA)}.

“I can make the system work for me but the two nurse assessors hadn't really got... they've got very basic rudimentary skills before, but because the proformas are there they can use them and we keep a folder until someone is sort of well in the system. We have got the hard copies filed and everything sorted. They keep it in the system until they can clear it so that they can go back if they need to add any more information.” {Locality One, Lead nurse co-ordinator (IPA) }

In *locality two*, at the time of implementation of FNC, the nursing home co-ordinator/lead nurse role was held by a nursing service manager acting as the implementation co-ordinator/ lead nurse and a service finance manager who looked after the FNC budget. No lead nurse was appointed at that time. Similar to

locality one, reasons for this structure appeared to have been more opportunistic than purposive, as illustrated by the following comment.

“[I took this on] because there was nobody else ... Well we didn’t, we didn’t actually have a lead nurse. And our clinical managers are clinical managers for the district nurses as well, and we were under quite a lot of pressure in district nursing, as a lot of people are. It wasn’t a massive role and it was something that I could do quite easily.” {Locality Two, Acting FNC implementation lead nurse (IPA)}.

Although other community nurses were trained to undertake determinations, only one part-time RN (RN 1) was charged with conducting them, on the basis that more than one person could lead to undermining a standardised use of the RNCC tool.

“I decided from the word go it was not going to be appropriate to have every single district nurse doing it [RNCC determinations] because we would not get any sort of standardised approach to the use of the tool. I mean quite a lot of it is subjective isn’t it, really, and if you at least have one person doing it you know that everybody’s being treated fairly. I think there would be quite a lot of difficulty if we had started to have too many people, although I know a lot of areas do have. I think they have all their district nurses doing it, don’t they?” {Locality Two, Acting FNC implementation lead nurse (IPA)}.

The perspective of the *locality two* NHS nursing service manager who acted as the FNC implementation co-ordinator was similarly, that the initial time-frame for the introduction of FNC was rushed. As reported below, this view was perceived as being shared by other NHS implementation senior staff who attended the initial implementation meeting at the DoH.

“We all, and it wasn’t just our Trust, many, many Trusts across the country expressed their enormous concern out of the speed that it had all been brought in ... things hadn’t really been thought through. If the Department of Health needs to learn one thing, I think it’s that they cannot bring things in as quickly as they do. And the anger at some of those meetings in London, of the people sitting there. I felt rather sorry. And, you know, nobody was listening. The clinicians and managers, everybody was saying ‘this is too quick, so we won’t bring it in until next April’. But I suppose it was a tick in the box for somebody wasn’t it, because that’s what it’s all about, it’s nothing about patients. It had a very rocky start, and we had to really, along with all the trusts actually, pull out all the stops to be able to make anything happen in free nursing care.” {locality Two, Acting FNC implementation lead nurse (IPA)}.

However, although staffing and other organisational issues were raised by several interviewees, in relation to the first few months of FNC implementation, these did not appear to have constrained progress in terms of meeting the initial completion target for determinations for self funding residents.

“The first three months weren’t easy. I mean we did get our determinations done on time, when they were supposed to be done, but the nurse [RN 1] we had actually did go off sick. She was a very, very good nurse at assessing, but certainly we had had some problems with sickness, and it was a bit of gamble I suppose. Then, there was a little bit of a wobbly, wobbly time really. {Locality Two, Acting FNC Implementation lead Nurse, (IPA)}

The NHS funded registered nursing care innovation caused a great deal of problems at first” {Locality Two, RN2 (IPA) }

By the time of the localities interviews in May 2003, the structure of the roles involved with FNC in *locality two* had also altered from the time of implementation to include the involvement of more staff. The FNC acting implementation co-ordinator had ceased to be directly involved with FNC and was replaced by the appointment of an FNC lead nurse. However, the financial manager continued to handle FNC budgetary issues but with the support of an assistant. In September 2002 a new part-time RN, [RN2], who also held a role as a community liaison nurse within the community team based in social services, replaced the original RN who left due to illness. In addition, another part-time RN and an administration assistant were about to take up posts. Reasons for these changes in the FNC work-force structure were due to the evolving pressure of increased FNC workload, as the following comment indicates:

“In actual fact now, although she [RN2] tries to do it on the one day a week, it’s taken over more recently. To get them [*determinations*] out of the way it’s taken more time. Social services have been very good, they’ve been very understanding, you know, we’ve managed to work the two roles [*the RN 2 determination role with her liaison nurse role*] in together.so I think in this PCT it’s [*employing RN 2*] worked well.Since [RN 2] has taken it over, the whole system has really bedded down very well. They’ve got systems in place now and we’re beginning to move on the concept of the post.” {Locality Two, Acting FNC implementation lead nurse (IPA)}.

The senior manager recognised that the RNs’ perspective of work-based support needs appeared to differ from the increased need for support as a part of a growing team approach:

“We’re hoping that it will be a team approach. A 30 hour F-grade is starting work with [RN 2] from May. I was thinking about putting a support worker in here, but at the moment we’ve got [IT Admin support officer] who you’ve met, who’s absolutely excellent, and at the moment [RN2] feels she probably doesn’t need a support worker. She can’t quite see where a support worker will fit in.” {Locality Two, Acting FNC implementation lead nurse (IPA)}.

The central role played by *locality two* RN2 was not undermined by the appointment of the lead nurse who appeared to have more of an administrative than a hands-on role in FNC. No audit system had been put in place by the time of the locality study’s interviews to ascertain the quality or consistency of RN2’s determinations, although this was perceived by RN2 to be a part of the newly appointed lead nurse’s role.

“In the fact of looking at whether the determinations are correct? Not, we’re not really, we don’t do any, no, the answer is no, we don’t. We don’t do any following up of determinations. Of [RN2’s] work? If there is ever a question about a determination not being right, we have opposite numbers in the other PCTs that work with us, that will come and do a determination to see if the result is the same as [RN2’s].” Locality Two, {Acting FNC implementation lead nurse (IPA)}.

“The lead nurse is responsible for audit.” {Locality Two, RN (CA)}.

4.3.4 Inter-agency working & inter-professional relationships

Participants reported both negative and positive aspects in engaging in inter-professional working. Connections and tensions were found around these relationships. Themes that emerged contained positive elements, such as where the determination process meant enhanced working practices leading to closer working relationship being forged (e.g. between nurses carrying out the determinations and care home staff). Positive aspects of the nursing determination process led the nurse participants to reflect on their caring role as well. This example is from a PCT nurse contemplating her role, as a nurse, in carrying out the determination process:

“I mean, one of the things that I, I always find really wonderful is when you go out and somebody’s gone out with a PEG and when you go to see them, sort of at the end of that three month period, then you actually notice they’ve got a swallow and things like that. And you say “You know? I think you ought to have the Speech and Language (therapists) in now. “ And things like that. And then you go back and see that PEG is out and you know they’re actually sat up there eating [...] And it really is, it always makes me feel really good, you know? That this person was really *very* ill. And you think, “Now, is this the right place for this person to go into this nursing home?” [...] But I find that, perhaps, with some of the smaller homes, they just need that sort of support from you as a trained nurse, to lead them in the right direction. And, and they’ll use you as resource as well, because they’ll actually ring you and say, you know, “What would you advise for this? Or that?” And so it’s really good.” {Location One, group interview, discharge nurse, older people’s team (IPA)}.

New ways of working also appeared to have actively streamlined FNC processes with time, and in accordance with other policy, by involving the care homes; establishing linkage between FNC and the SAP; avoidance of duplication of information; and the development of quality assurance through audit and review mechanisms involving other PCTs.

“And whilst we’ve been doing the Social Service funded, you know the local authority funded, we’ve actually done an appointment system, it’s all been done in co-operation with the homes so they’ve [RNs] packed in about 5 or 6 at a time, in a morning or an afternoon and then they come back in to write up the documentation. “I am working very closely with our contracts departments with the service manager from the borough council to really get that cohesiveness going. So we had a meeting last week and we have called ourselves the fob group. It’s simple things like making sure that when we talk about out of area placement, Social Services will mean one thing, health may mean another, so we are actually setting up our own glossary of terms to make sure and identify the different groups of residents that we may have to deal with.” {Locality One, lead nurse co-ordinator (IPA)}.

Tensions reported included issues around joint working with social care and with nursing colleagues, for example with those working in care homes. Some of the more negative aspects centred on the ‘them and us’ attitude contained in the interview data.. This ‘professional tribalism’ is thought to stem from the way professional identity is emphasised during training, especially in healthcare. Specialist knowledge and the complexity of today’s health and social care systems create enormous professional diversity, while, at the same time, professionals are being increasingly encouraged to deliver care *across* these professional and organisational boundaries. Managing and maintaining these boundaries is part of this complexity (Holt, 2002). However, the creation of these ‘tribes’ leads to different groups in health and social care

organisations and this is thought to contribute to communication difficulties alongside the increasing complexity of division of labour in inter-professional working (Peckham & Exworthy, 2003; Beattie, 1995). As Sandra Dawson observes “It is a critical managerial task to find ways of enabling communication between the worlds, of creating synergy, but without losing the benefits of specialist knowledge.”(Dawson, 1999). The interview data contain many examples on this theme. The following extract, from a group interview is one such example:

Int 1: “they can still use us as a central point [...] to start with...”

Int 2: “And they know, you won’t, you won’t ring them back immediately, they’re used to that. They know that X (Int 5) I only work, whatever?” (*emphasising to the lead nurse co-ordinator that she’s not always immediately available*)

Int 1: “Yes, mm, I mean we’re not an *acute* service. We will respond in a timely, supportive manner. I think Social Services, social workers think they’re the best thing since sliced bread at the minute you know, so you know! Just help out and you think...yes, pardon?”

Int 3: “We know one or two who don’t think...” (pulls a face)

Int 1: “Out there in the community, because they haven’t had that support, and they’ve had to make some very radical decisions without, the lack of knowledge...and not quite knowing who to ask.”

Int 5: “They’ve come to respect that haven’t they? That’s the interesting thing. Social services totally turned round in the community.”

Int 1: “If you actually look at our message book – I actually had the time to audit it! A lot of work we do is supporting the professionals. You know, that they think of us as a resource and you know, I don’t want to start, but it’s *very* time consuming.”

{Locality One, group interview, Services for older adults team (IPA)}.

Several such tensions and contradictions are illustrated in this extract. The lead nurse/ co-ordinator attempts to ‘manage’ her team, by reminding them to act responsively in a “timely supportive manner” in relation to the determination process and delivery of nursing care, as well as advice on inter-agency working. There is also the challenge of joint working with social care and hints of the tribalism discussed above with her reference to “social workers think they’re the best thing since sliced bread at the minute.”

Some tension was also reported between care homes and hospitals, with some of the nursing staff working in care homes feeling that they were 'looked down on' by hospital staff. Evidence of this was found in both locations.

"I think there is a great divide between nursing homes and the hospitals [...] I find I can go somewhere and get all the help and assistance that I need. And then I'll go to another ward and you're looked down on. You're regarded as a second-rate nurse because you work in a nursing home." {Locality Two, Matron care home (IPA)}.

Other comments centred on nurses who had moved into care home management or into care home nursing. They felt that other professional groups sometimes questioned their nurse training background, now that they were working in a care home, rather than a clinical setting and feelings of being undervalued were also reported by staff in the care homes

"You are seen to be slightly biased, no-one would really take any notice of your professional opinion [...] I actually found that quite derogatory about my professionalism really." [Interview 3, interviewee 6. Care home manager - also a qualified nurse, 1st care home, PCT One. 1:41-48]
"I feel, you know, if you work in a nursing home, you are under valued by the Health Authority."
{Locality Two, Matron care home (IPA)}.

Joint-working was also discussed in relation to care home residents being admitted to hospital and hospital discharge, the theme of *links with hospitals*. Comments here centred on both working with other health professionals, who might have a different perspective to the nursing care model (e.g. general practitioners or hospital medical consultants), and social service staff, who might assess someone for a care home place before discharge.

"They have a medical model in their head rather than a joint medical-social care model that I think, more and more, we are delivering in a community setting in people's own homes." {Locality One, lead nurse co-ordinator (IPA)}.

One interviewee's comments in relation to working with general practitioners on the issue of residents' (re)admission to hospital from a care home are given below.

Int 1: "We've got to not just re-educate GPs. GPs need to come on board to realise that the simple answer isn't just to re-admit people from a nursing home into hospital. The registered nursing care is there (i.e. in the nursing homes). It's what services can we bring to the person to prevent them going into hospital? Or at least have a controlled admission, which re-stabilised them. [...] But it's also about bringing the nursing staff in the homes on board. We can't expect them to deliver what they haven't been trained to deliver."
{Locality One, group interview older adults team, lead nurse co-ordinator (IPA)},

While NHS professionals were hopeful that there were increased opportunities for inter-agency working with the organisational changeover to PCTs, there was acknowledgement that truly integrated working practice was being slow to get off the ground. This was thought to be due to factors such as the different professional backgrounds found in health and social care, bureaucracy, the differences in 'jargon', staff working with different codes of practice, misunderstandings and working across different, non-compatible, computer systems which meant it was sometimes hard to access and share information.

"We just have to sit round the table and discuss with our Social Services colleagues, almost on a patient-by-patient basis at the moment, which could be better." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

The themes of *Inter-agency working* and *sharing information* are closely connected to the category of *Communication* since efficient and timely communication forms the basis of good professional working relationships.

4.3.5 Information

Sharing information focused on the burden of documentation-paperwork as well as electronic systems. Discussion on information and communication systems (ICTs) centred on such issues as access to, or sharing of electronic databases. The linking of computer systems, such as networked systems or the use

of, and access to e-mail by staff in the PCTs were also discussed. Documentation for the determination banding decisions was another theme contained in the data. Discussion focused on the amount of additional paperwork generated by the new FNC process and also of how data were then stored, ease of access and sharing.

Both locations were moving towards electronic systems for data storage but neither had totally achieved their objectives of having all information available in electronic format and accessible by both Social Services and health professionals.

"We haven't managed to amalgamate the computer systems, which I expect (name) has told you about. We very much wanted to go to a single system, but our Social Services said they couldn't cope with that at the moment. So we are having to set up a new database that will really take on all the extra patients, which is very costly for the PCT." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

If data was held electronically there was also hard copy and some staff cited the need for more IT training.

"We have got the *proformas* on the computer. We are perhaps - cart before horse here - we've not really accessed as much IT training as we would like, but that is one of our team objectives in the next couple of months now so that the nurse assessors actually get some more IT training so that they can use the systems and have some shared domains to deal with things [...] but the two nurse assessors they'd got very basic rudimentary skills before, but because the proformas are there they can use them. And we keep a (paper) folder until someone is, sort of, well into the system. We have got the hard copies files and everything sorted. They keep it in the system until they can clear it so that they can go back if they need to add any more information." {Locality One, lead nurse co-ordinator (IPA)}.

For other staff, sharing information was considered rather a challenge when not all their team members had access to e-mail. This became more of an issue when members of the same team were working from offices in different geographical locations while trying to provide an integrated service for older people in the PCT. This was a problem for staff in both locations.

"Time is of the essence [...] You've got one contact number (between you) at the moment, is that right? We don't have mobile phones as such so having you on e-mail would be absolutely wonderful. [...] And that is something that you, I think, are missing out on, that information sharing, as well as that basic communication tool - because we're used to having e-mail."
{Locality One, Joint interview with team meeting between PCT Lead Nurse Co-ordinator and District Nurse Liaison Team (IPA)}.

"We haven't even got all our district nurses able to access computers. [...] I think it is getting better, at least the GPs are networked now. And those district nurses that are actually out-posted with their GPs are inevitably networked with them. But they can't talk to any of their opposite numbers because they haven't got computers. So it's very basic. We have, I mean, there is a system - we were promised them last April. And there certainly is a programme (for IT) - they are beginning to put them into health centres. But it gets quite frustrating because it's very slow."
{Locality Two, Acting FNC implementation lead nurse (IPA)}.

"We never get any information from the Trust here.
Do you have a computer you could access the web from, in the home?

No [...] it would be nice if it could be here, because there is a computer here" (i.e. not networked to internet access) [...] I think their feelings (i.e. the care home owners) are that, you know, if they've got it at home and they're using it, then it doesn't need to be here (for staff)" {Locality Two, matron care home (IPA)}.

Other participants were finding difficulties in accessing information that was available in an electronic format if it was not networked, or if they could not access the office computer.

Researcher: *Can you look at this online then? Could someone else access it from another computer, somewhere else?*

Interviewee: No because we're not networked.[...]

No, everything that's on there is just a stand alone [...] which has caused a few problems because sometimes I haven't been able to come in here to use the office [...] everything I do is on here (this computer) It can be a bit tricky.

Res: *Are there any plans to network?*

Int: I'm not sure, I think there are but there are a lot of changes going on here anyway.

{Locality Two, lead Nurse (CA)}.

There were, however, many examples of people working in an innovative and pro-active manner to solve information sharing problems at a local level.

"There's a lot of paperwork that needs to be sorted out. I'm trying my hardest to try and get in onto there (computer) so that we haven't got to sit down and write them. I've got 200 determinations to fill out for the Social Services people, so I'm trying to get it automated so that we don't have that hassle. [...] I draw out as much information as I can from the system I know. Generally speaking they are on there, particularly if they're Social Services. So I prepare that, make an appointment with the ward, or the nursing home and (name) goes along to assess (for determination). When she returns I then go back into the (name of PCT system) and put the results of the assessment on there so that the social worker can pick it up for the banding funding. [...] I've also developed, I have one main spreadsheet which, basically, takes in all the information that we need." {Locality Two, Acting FNC implementation lead nurse (IPA)}.

NHS professionals also highlighted teething problems that had occurred using different IT systems for the new FNC banding process. Implementation of FNC was considered to be a steep learning curve, as illustrated in the following excerpts related to funding and finance of FNC.

"And that was, again, about mistaken identity at the time when nursing home managers, or owners, were asked to identify privately funded residents. It's down to their systems really, but we, well, that was when the Health Authority accepted their word. There was no way of checking that out really. You had to accept that, and it's a very sensitive issue." {Locality One, lead nurse co-ordinator IPA)}.

"There is a lot of confusion. The NHS and Local Authority computers are not compatible. There is poor communication and payments are not on time. The banding money is paid to the home and then we have to do all the re-payments." {Locality Two, care home owner –manager, 4th care home (CA)}.

4.3.6 Finance

In practice, the introduction of banding levels and payment system was perceived by some staff, as quite a complex process. From the point of view of the care homes, they found the new system acceptable. As they were running a business, it helped with their cash flow, because the money was paid directly to the home. Nevertheless, care home administration and management staff did also point out that with this funding change for residents, it meant that they had an additional 'administrative load' and cost to them, since they had to find the money to pay for staff hours to deal with the new funding. Again, as with the implementation of FNC, some of this time may be the care home staffs' perception of the time spent with implementing a new system.

Care home staff did express some reservations that the lowest banding level did not fully cover the nursing care provided for residents and homes could be losing out financially.

"The only people that are losing out, as far as the low band is concerned, is the owners. Because of the way that Social Services have restructured their nursing care costs I'm losing for the owner upwards of a pound (sterling, per patient) a week [...] which is going to be a big issue." {Locality One, care home manager 2nd care home (EMI), (CA)}.

The new banding system was also causing NHS staff some anxiety, since they had to get to grips with managing financial issues. While they were rising to this challenge, they acknowledged that they felt in need of some additional support or training.

"I've never worked so hard in my life! [...] Professionals have struggled to understand the guidance and the complexities of it [...]. I think having the three bandings one has to wonder why and I would be interested to see how the Welsh model of having one banding is rolling out. If you actually balance the level of need against the cost, will it make that much difference if we had just one standard banding? [...] Because of course the bandings in themselves create contention because people believe that the person they love meets a high banding." {Locality One, lead nurse co-ordinator (IPA)}.

Families of care home residents also found the financial aspect of the banding decisions rather difficult to understand.

"I want F (wife) to have what she's entitled to. I mean both of us volunteered for the Forces, both of us paid all our taxes, do you know what I mean? We didn't have a penny when we started out, the fact that we've got something there is solely because we saved. [...] to me it's illogical (banding) [...] you see it's logical to have them. But how do you impose a sliding scale?" {Locality One, husband of care home resident with Alzheimer's disease (IPA)}.

Inevitably, with the implementation of a complex new system, there had been some instances of financial errors. While these were in the process of being corrected, NHS staff felt under some considerable strain due to the extra work involved, and the burden of additional responsibility.

"I have got part payment back from one home but the (nursing) home-owner is now challenging that. He's not prepared to pay the rest. We (PCT) should be collecting that. And, of course, their argument is that they are doing this for nothing. They are actually administering funded nursing care. They've not had any administration fees or anything, which is perhaps a valuable thing to take on board. But, ultimately, in legal terms, they were the ones who made the mistake so they are the ones who should recoup the debt but they should be paying – that's the stand that our Director of Finance is taking. The other case that I am trying to challenge – the home went into receivership so we are not going to see much of that. It is going to go as an 'unsecured debt' but, again, yes, it is just a new skill I am learning! [...] I am not a trained accountant. I keep saying "I am only a nurse". I mean, they are very good but, again, our Finance Department – this is just one of the plates they are spinning basically. I think there is an awful lot going on. We are a PCT with an inherited debt from the former systems and we are actually having to go into brokerage with the Strategic Health Authority which I am sure is the biggest headache for our Director of Finance and our Chief Executive. They have that much bigger picture of responsibility than ourselves but they had to pick up and run with Funded Nursing Care." {Locality One, lead nurse co-ordinator (IPA)}.

NHS staff were taking responsibility for managing their 'own' budgets very seriously and were obviously actively engaged in trying to make the new system work. At the same time they considered it a considerable challenge which at times, they found rather stressful.

"But obviously from April 1st we were, we were actually purchasing that registered nursing care. So we don't underestimate now our responsibility. And my worry is that we've not really taken on board here what was expected [...] I think we have to get a lot better, we have to formalise it. But nobody's put a minute into doing that. Now if the Department of Health are expecting us to deliver that within PCT means, we can do our best, you know? For instance, the catheterisation training has gone over-subscribed now. [...] And not only are the two sessions full, we've had to plan another session, which is great. But then the staffing, nursing homes have to develop the competencies. It's not just about going on a morning's training is it? It's about how they, they deliver that competency." {Locality One, group interview, older people team (IPA)}.

The excerpt above shows the process of change and perceived complexity of FNC. FNC documentation was a source of both negative and positive comments. Participants also showed awareness of the need for *change* despite the apparent *complexity*.

4.3.7 Communication

Good working relationships were thought to depend on opportunities to meet and discuss cases, and on a willingness to share information and communicate in a thoughtful and timely manner. However, more work was thought to be required to aid effective communication so that in the future the delivery of care might be improved. This is where FNC was viewed as a catalyst for improvement and could contribute to driving change, such as using a common terminology.

"But for things like this (Alzheimer's resident in care, wandering etc.), their [staff at SHA, social services] terminology is slightly different. So I am actually going to put this to the team tomorrow to think (over). Should we change our terminology to reflect the same as Continuing Care? We have a slow process. If we use the same terminology we should all mean the same thing basically." {Locality One, Lead nurse co-ordinator (IPA)}.

The changes introduced by FNC caused some initial hiccups. Interviewees considered that these were mainly due to misunderstandings and that good communication and persistence could overcome them.

"Initially a lot of the social workers were very against it (determination bandings), and were unwilling to accept it, and kept quoting their criteria. But fortunately, by working with the fairer nursing group and going to their senior managers, it has eventually filtered through.[...] So I think it's been a big education for social workers, and I'm actually finding quite a lot of the social workers now are finally saying "I think they're (i.e. resident) for nursing" and they are actually prepared to listen to me. [...] I think they're now starting to realise that I'm not saying these things as a means of getting more money for the company, so to speak." {Locality One, 1st Care Home manager - a qualified nurse (IPA)}.

"Social Services need to be questioned in ways we've not done it before - about why they're not doing something to assist an individual. And then pull that together with what's going on here in the home. [...] The organisation's not been there to do this sort of thing before." {Locality One, 2nd Care Home (EMI Home) Manager (IPA)}.

Communication and access to information and *information sharing* were also discussed in relation to inter-personal communication in the workplace.

4.4 RESULTS: THEMES FROM SERVICE USERS' PERSPECTIVES

Users' perspectives. The main findings were:

1. Overall, themes identified from professional viewpoints mapped on to themes identified by users.
2. Awareness of RNCC determination was low despite local and national publicity.
3. Families were not aware that they could be present during determination.
4. Families did not have much awareness or understanding of FNC funding, or appeals.
5. With some exceptions, communication about RNCC with service users was not prioritised and communication could be improved by ensuring that information is given in a consistent and timely manner, with reference to its statutory framework.

The same thematic categories as found in interviews with NHS staff and independent sector care home managers, recurred in interviews with care home residents' relatives and content analysed. NB. The one other relative, whose wife was a care home resident in location one, whose interview was audio-taped face-to-face, is included in the IPA analysis (see section 4.3).

4.4.1 Determination

The most noticeable feature of these interviews conducted with relatives of care home residents was their overall lack of awareness on the subject of FNC determination. All expressed doubts as to whether they knew anything and did not appear to have any information about FNC, despite the publicity in the national press. Several of the participants stated that they had no knowledge how nursing care for their relative was funded. Some participants remarked, rather hesitantly, that they had "received a letter" but these people seemed to have either misunderstood the contents of any such letter or were confused about the costs of funded nursing care their relative might need while resident in a care home.

It should be remembered that these are the perceptions of the participants. Understandably, how carers perceive the delivery of care for their loved-ones is likely to vary for each person. The circumstances of each situation are different, and their views are likely to differ from the perceptions of NHS professionals. These findings are the participants' own views and opinions and this carries the authority of service users as 'customers' or 'citizens' (Donaldson, 2003; Eaton, 2003; Sakala, Gyte, Henderson et al., 2001). This research was on the delivery of care for older adults, hence their role or status is important to the study.

The service users interviewed had previous experience of caring for their relatives before they moved into care homes, an instance of the older person as 'expert consumer' (Hayden, Boaz & Taylor, 1999). However, these carers did not appear to have received information which they considered they had needed about FNC.

"We had a letter saying there will be changes [...] I have never heard of any determination or assessment, of registered nursing care that Mother needs. I would not know if Mother has had anything like that."
{Locality Two, son of care home resident, 4th care home (CA)}.

"I have heard of NHS funded nursing care but have not really read anything about it."
{Locality Two, daughter of care home resident, 4th care home (CA)}.

If care home residents' relatives were unaware of FNC in general, it followed that they were unlikely to know that they could be consulted about the determination, or could be present when the determination was carried out. This was, indeed, what participants reported.

"I have not been asked to attend or been notified of any determination or assessment that Mother had to have."
{Locality Two, daughter of care home resident, 4th care home (CA)}.

"I haven't been told of any assessment and I've never been invited to come to any meeting about my mother – but the Social Services saw to all that." {Locality Two, husband of care home resident, 4th care home (CA)}.

This was further confirmation of the findings from the in-depth interviews with professionals that the determination process, in both locations, was often being carried out without consultation with, or the involvement of, care home residents' relatives. This is not conducive to the appropriate delivery of care that is respectful of older adults (Clark and Spafford, 2001), for either the resident or their family member (since many residents' relatives are themselves likely to be older adults).

However, in both locations, care home staff were also very busy. Under such conditions it is understandable that care homes would not want to risk worrying or unsettling their residents, especially frail and vulnerable older adults, who might also be suffering with age-related mental health problems. The task of informing and arranging appointment times when relatives of residents could attend a determination meeting that also

fitted in with the schedule of the RN who would carry out the determinations was viewed by care homes as one task too many to fit in to an already over-busy day.

(i) Appeals

As with other aspects of FNC, this group of participants did not seem aware that they could appeal against the funding level allocated for their relative if they had any concerns about the banding decision. No members in this group (4th care home) volunteered any information about appeals or said that they had wanted to query the banding level allocated. Given the general lack of awareness among these service-users, it appears likely that this group would be unaware of the appeal procedure. However, we cannot be certain whether this is due to lack of information or if it reflects an opinion that they saw no need to appeal, even informally against determination outcomes.

Only one participant from location one *did* have experience of attempting to query the decision. He had found the appeals system both upsetting and very frustrating. He had objected to the banding level allocated to his wife who had Alzheimer's disease. In his opinion, she needed a high level of banding for her nursing care. Nevertheless, the decision had been made that she was to receive the middle band level for the nursing component of her care. Her husband, who visited her twice a day, also thought that because of her medical condition and fragile state of mental health, she should be classified as in need of 'continuing care'. This was made all the more poignant since, in his follow up conversation with a member of the research team, he told how his wife had died before his appeal had even been considered. He felt that:

"I don't have the heart to deal with it (appeal) - not now." {Locality One, husband of care home resident, 1st care home, (CA)}.

He recounted, with some perplexity, how his appeal had first been sent to the wrong area (a strategic health authority) then to a neighbouring PCT before finally being directed to the correct PCT for consideration by their appeals process. This administrative mistake had compounded his feelings of despair and frustration. It was made all the more difficult for both the service user and the care home and NHS staff who still had to communicate with one another while his appeal was in this state of transition.

The independent professionals in his wife's care home held a rather ambivalent attitude towards this participant. This has been noted elsewhere, especially in relation to assertive carers (see, for example, Twigg and Atkin, 1994). Staff knew that he was unhappy with some aspects of FNC and the banding decision, yet, at the same time, it was important that they maintained civil communication on a regular basis for the sake of his wife. It would appear that they had managed to achieve a level of compromise and that these negotiations had been handled with some tact and civility on all sides, by the carer as well

as NHS staff and the care home staff. This participant, like the other interviewees, did acknowledge that he was happy with the quality of care.

4.4.2 Care

The theme of *respondents' voices* (contained within the super-ordinate category relating to *Care*) is an example of an identified contradiction found in the data, since participants' own voices, opinions and concerns are not numerous. They appear to have answered the telephone interview questions rather passively and it is noticeable that they do not 'open up' the conversation, with a remarkable lack of comment reflecting the actuality of their lived experiences. However, as discussed above (section 4.4.1), a reported low level of awareness of the determination process was observed generally. As this group of service users were not fully informed, it then becomes much more problematic for them to venture an opinion about a system that they do not fully comprehend. What is evident is a common attitude of expressed gratitude combined with passivity. Perhaps, as in the discussion on caring and carers above, this is a manifestation of their relief that their loved-one is in receipt of care and no longer reliant on care from the carer alone. Metaphorically, they have had a large portion of the 'burden' of care lifted from their shoulders. One participant did describe his carer's role in this way and the relief he experienced once his wife, who has dementia, moved into a care home.

"I try to go and see her every single day [...] I keep going in because it is better for her to see me every day - you know? I think it helps but it is hard for me as I am not well and the walk there is difficult for me every day. I have my son at home and he is a help to me. We do our best to help."
{Locality Two, husband of care home resident who has dementia, 4th care home, location two (IPA)}.

This is contrasted with the carer's role described by an interviewee in location one. This participant's wife had Alzheimer's disease and was now resident in a care home. He also visited his wife on a daily basis but, in his case, he did not view her move into a care home as a relief but rather as a decision that he had reluctantly felt he should agree to (see earlier in section 4.3.1 (vi)), where he describes being "disappointed" that he could no longer care for his wife in their own home). A strong theme threaded through his interview was the narrative of both his and his wife's situation in life and how circumstances had brought them both to their current state. He described how devoted he was to his wife (they had been married for 50 years) but also his sadness at her now being ill with Alzheimer's disease.

"My view of Alzheimer's I can't repeat but, quite honestly, if somebody had said to me that I could only have twenty years with (wife's name) I would have taken it. I think I still court her, can you understand? [...] It never stopped, you know. [...] I only have three regrets in my life. One is that (wife's name) got Alzheimer's and she was two years younger than her sister, who got Alzheimer's as well in Australia. So in a way, I was warned of all the problems that was going to be happening, you know?" {Locality One, husband of care home resident who has Alzheimer's disease, 1st care home, (IPA)}.

As with the previous interviewee (location two), this participant was also visiting his wife every day thus illustrating the enduring role of the carer in their devotion to their loved-ones.

“When they get her (his wife) up – and it’s only just before dinner that they get her up. You see? I come for lunch, I come for tea and I come for the last hour at night. And so I go to see (name of wife) on [at least] two occasions – the lunch and tea. And there’s a lovely bay window, not got a wonderful view, but at least it’s a bay window with a seat in. And it’s ideal for me to sit on the seat and (name of wife) to be able to – because she’s in one of those roll around chairs – for me to feed her. And I think that’s a prize for (wife’s name). Because when I leave her, the people are walking past her, all saying “Hello (name) how are you?” and you know, and it’s better than her being in her own room. And I wouldn’t wish my own enemy to be in the lounge area, because – well – life is difficult in there” {Locality One, husband of care home resident who has Alzheimer’s disease, 1st care home, (IPA)}.

However even those participants who were very committed to their loved-ones and who had devoted time and energy to researching into obtaining the ‘best’ care for their relatives and spouses displayed uncertainty and a lack of knowledge on issues relating to FNC.

4.4.3 Information

Participants did not appear to have been notified about their relative's determination for FNC. It also became apparent from the interviews that they had not been offered the opportunity to be present, as an advocate for their relative or spouse, during the actual determination. This was further confirmation of the findings from the interviews with NHS professionals, that the determination process, in both locations, was often being carried out without consultation with, or the involvement of, care home residents’ relatives. The comments about attendance at determination are repeated here (see section 4.4.1).

“I have not been asked to attend or been notified of any determination or assessment that Mother had to have.” {Locality Two, daughter of care home resident, 4th care home(CA)}.

“I haven’t been told of any assessment and I’ve never been invited to come to any meeting about my mother – but the Social Services saw to all that.” {Locality Two, husband of care home resident, 4th care home (CA)}.

4.4.4 Finance

Once again, relatives of care home residents seemed very unaware of how FNC funding worked in practice. This would, of course, depend on their level of awareness regarding the determination process (see section 4.4.1). Actual knowledge of funded NHS nursing care for care home residents appeared to be low among those interviewed, in both locations. However in location one, one individual (male, interviewee 7, 1st care home) was very well informed about financial matters (see section 4.3.6). He had researched thoroughly the financial side of FNC because he wanted to secure the 'best' care for his wife. Prior to his retirement he had been professionally engaged in financial management. To him the banding levels seemed "illogical" in relation to the provision of NHS funded nursing care for his wife. He loved his wife dearly and felt he was battling against a complicated system at a time when he wanted to spend more time with his wife.

Subsequent to the original interview he contacted a member of the research team, following the death of his wife. He re-iterated his disappointment in a system that seemed to him to have been slow to respond to his concerns. He considered that the answer did not lie in devolving funding to the PCT level. He had formed the view that the local PCT did not have the expertise to deal with the complexity of financial protocols and processes relating to the delivery of nursing care for older adults. His concerns were that the practical delivery of care needed to work more efficiently and this would be more likely to occur if organised and run in a centralised manner.

"You tell the Department of Health, *please*, that centralisation is needed here." {Locality One, husband of care home resident, 1st care home (CA)}.

Other participants gave the impression of being less well informed on this issue. The main focus of their comments centred on a perceived lack of awareness about how the nursing care component of care was funded. In most instances it was apparent that the care home matron had attempted to inform some of the residents' relatives and help them to apply for funding. These people seemed grateful for her help and viewed the care home matron as someone who was helping them sort it out. This reported experience links to the themes of *nursing role*, *compassion* and *quality of care* contained in the categories of *Care* and *Quality* from the in-depth interviews.

"I don't know of any assessment or determination but Matron advised me that some refunding would be available and sorted it out for us. We have had our bill reduced and it is very helpful."
{Locality Two, daughter of care home resident, 4th care home (CA)}.

It remains unclear, however, what the exact role of the care home matron had been in these situations and what information she had actually given these residents' families. Given the seemingly low level of understanding reported to the research interviewer, it would seem that these service users received minimal information of questionable quality. It may also be, however, that the care home matron made the decision, from a nurse advocacy perspective that helping with the funding for funded nursing care was something she could undertake to make life easier for her residents and their families. Her approach would appear to be, from the service users' perspective, that of someone who was attempting to reassure and 'smooth the path of care' rather than of one who was deliberately setting out to under-inform.

"Matron has mentioned something about a new system of payment from October 2003 but says it will not make any difference as the local authority is supporting Mother. She doesn't have any savings." {Locality Two, daughter of care home resident, 4th care home (CA)}.

Nevertheless, the fact stands that residents' families appeared uncertain both about how NHS nursing care was funded and accessed and about the determination of the different levels of this funding (i.e. the three different banding levels).

"I applied for a nursing allowance because of the high cost. Matron organised this for us and now we have some financial support from the Health Service. Matron has been very helpful. I think it's called a 'high banding' amount that we get help with but I'm not sure." {Locality Two, daughter of care home resident, 4th care home (CA)}

4.4.5 Quality

In spite of lack of knowledge about FNC, all the participants all expressed the view that they were happy with the standard of care their relatives received in the care home. Care staff were described as being "kind" and "helpful" and being "good" towards their relatives.

"She (i.e. Matron) is very kind. [...] We are very happy with how mother is cared for." {Locality Two, son of care home resident, 4th care home (CA)}.

"Matron is very helpful and kind to the residents." {Locality Two, daughter of care home resident, 4th care home (CA)}.

It is likely that these participants had been caring for their loved-ones before the relative became a resident in care home. The emotional and physical stresses attached to the role of a carer (Nolan, Grant & Keady, 1996) can be such that, for some, it may come as a relief when their relative moves into a residential care environment.

"The nurses are good to her. [...] They look after her so well it is a relief to me. I am happy with the care at the home, They are kind." {Locality Two, husband of care home resident, 4th care home (CA)}.

"It is a help to us. [...] Mother's care is excellent since she went into the home." {Locality Two, daughter of resident, 4th care home (CA)}.

Many carers provide care all day and every day. It may become very difficult for one carer, now matter how committed, to provide quality care consistently. In such cases, especially for carers who are also older adults, the quality of the care that can be provided by trained professionals may prove to have benefit for both carer and the cared-for person. Related to this point are the themes of *Respondents' voices and issues relating to care and service users and communication*.

4.4.6 Communication

As noted earlier, knowledge and awareness of FNC procedures, *communication with service users* would appear to be a low priority at both the PCT level and at the individual care home level. This was particularly evident from the interviews with relatives conducted in location two, but was less evident, although still present, in location one. Interviewee 7 (location one) had attempted to rectify the poor levels of communication he encountered by undertaking his own research into FNC. He became a fierce advocate for his wife, especially in relation to obtaining information and support from the voluntary sector (Alzheimer's Society and Age Concern) and advice around the procedure for acquiring a more

suitable wheelchair for his wife's comfort, after an initial request had been postponed and labelled as 'low priority' by administrators in the PCT.

"I mean, once I lost control of (wife's name) [i.e. she went into a care home] I felt as though every minute, my only aim then was that (name) would have the *very best* that I could provide. [...] I did most of the research [...] And what I did was to go talk to the Matron, ask her all the questions from what I could see. [...]

Thanks to a lot of effort...I should say, I should say – I've got to say this – that when (name) came here (care home) the Age Concern representative came, and we had a meeting of some kind, and they decided that they would apply for a wheelchair for (name). It was obviously, what was required was a special wheelchair because she was immobile. Her legs stuck out, you know? That was in February, not this year, but last year. And in August we got a letter...another letter to say that, because (name) wasn't a 'high priority', it would be at least another three months before we got one. So I sat down and wrote a letter to the head of the, you know, the wheelchair section, and I got a phone call to say that (name) would get one in two weeks.[...]that's why I didn't agree with everything you said about (care home manager), do you know what I mean? Really I shouldn't have had to do all that I did, full stop. But never mind. In the end I got it.

You're championing for your wife now, aren't you?

Always, yes. I'm fighting now."

{Locality One, husband of care home resident with Alzheimer's disease (IPA)}.

In telephone interviews in location two communication again centred on the negative rather than the positive, and linked to the themes of *service users' awareness of determination* and *knowledge they could be present during a determination* (see section 4.4.3 above). Again, participants professed a lack of knowledge about the process.

"No, I've never read about anything like that. Matron has mentioned something about a 'new system'

{Locality Two, daughter of care home resident, 4th care home (CA)}.

For another participant, whose mother was a care home resident, communication had taken the form of a letter which, as he had not understood the contents, he had ignored.

"I didn't take much notice of this." {Locality Two, telephone interview with son of care home resident, 4th care home (CA)}

Any communication that had taken place appears, from the interviewee's perspective, to have emanated from individual NHS professionals and care home staff who 'mentioned' something in such a way that service users believed they received it on an *ad hoc* basis. Data from this study suggest that it would be helpful if communication with service users' families and relatives were improved by ensuring that information is given in both a consistent and timely manner and with reference to its statutory framework.

4.5 SUMMARY OF FINDINGS FROM STAGE 3

In summary, the main issues which concerned respondents, in the implementation of the RNCC funded nursing care, were related to the themes of the *Determination process*, *Care*, *Change*, *Inter-agency working*, *Communication* and *Information sharing*, *Finance issues*, and *Quality* of the process. While it was perceived as being a very *Complex system* to understand, people did acknowledge that nursing care for care home residents was a vital component of care provision. Although there were some reservations regarding the initial implementation process, the professionals involved in providing care were trying very hard to make the new system work for their care home residents. Professionals' sense of stress in relation to what they were being asked to accomplish centred round the time-scale and their value base. Many people felt that the new system had been implemented in a hurried manner and they felt unprepared for what they had been asked to deal with. An acknowledgement of this time pressure, by giving staff more flexibility to complete the determination process with a relaxation of the government time-frame to achieve set 'targets', would be welcomed by staff and could contribute to a lessening of their sense of stress.

NHS staff had also been distressed by some of the more difficult cases they had encountered, although the FNC process for those care home residents would lead to a more appropriate package of care. The three levels of banding were not always understood, either by the care home staff or by residents' families. This, and the recent publicity generated by a campaign in the media, had led to many people feeling confused, and to the new determination process being viewed with some suspicion. From an analysis of the views of the people interviewed, greater transparency regarding the process would be greeted as a welcome improvement. Furthermore, the different levels of banding need further clarification and explanation if the public are to understand them.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 CONTEXT

5.1.1 Provision of long term care

Over the last 20 years, changes in health care provision have resulted in increased reliance on community services, fewer hospital beds, and reduced length of stay (DoH, 2000b). Between 1983 and 1996, the number of NHS beds for older people fell by 38% thereby focusing the NHS role towards one of acute care provision. By 1995, the decrease in public sector beds had encouraged an increase in independent sector provision to an estimated 288,750 people aged 65 and over in residential care and some 157,500 in nursing homes, as compared with 34,100 in hospital (Royal Commission, 1999). The issue of long-term care and how it should be funded has previously been widely discussed in the literature (Deeming 2001; Deeming & Keen 2000; Hancock 2000; Parker & Clarke 1997). At the same time, increases in the number of older people in the UK, and especially those aged 85 and over, are well documented (Royal Commission, 1999; Foresight Ageing Population Panel, 2000; Audit Commission, 2000a; Audit Commission, 2000b). Many diseases that cause dependency increase with advancing age and eventually give rise to some type of continuing health and social care need.

It has been estimated that there are now some 140,000 beds in the registered care home sector, a 10% reduction on THE 1995 figure (DoH, 2002b). Of increasing concern is the closure of homes resulting in a loss of beds, estimated at some 34,000 over the four year period 1998-2002 (House of Commons Health Select Committee, 2002). In establishing reasons for home closure, Doohan (2000) in a report for the Independent Healthcare Association (IHA) has drawn attention to the reported escalation of staff costs of between 5 - 10% per annum for independent sector care providers (cited: Pay and Workforce Research, 2000). In a later report by the same author (Doohan, 2001), it was noted that there was a £60 deficit per person between the Preserved Rights Income Support rates, used by many local authorities to set base-line fee rates, and the costs of meeting care in nursing and residential homes, as given in figures provided by the Personal Social Services Research Unit, University of Kent (Netten & Curtis, 2000). In taking note of the implications of home closures upon the health system as a whole, the Department of Health has called for an increase of some 6,000 places in care homes over the next three years (DoH, 2003b).

5.1.2 The climate of care in the independent/ voluntary sector

It has been argued that traditionally there has been a failure to appreciate the requirements of older people in long term care establishments and the need for environmental and independence-promoting skills (Nazarko, 1995). Thomas (1995) has argued that for decades policymakers and health professionals have considered

older people's care needs to be 'basic' rather than complex. It has also been suggested that by moving long term care from hospital into the independent sector, these values have been transferred into the latter, creating a climate of difference between the now more acute care offered for older people in the public NHS sector from that offered in the independent sector (Phillips *et al*, 1988).

In this context, the introduction of RNCC determinations has brought NHS nursing staff into care homes on a regular basis for the first time, including scrutiny of care home notes and consideration of nursing care needs.

Within the independent sector it is recognised that there are differences in the management of homes and access to NHS nursing expertise. In a recent research study focusing upon management in care homes (Chambers & Tryer, 2002), well-managed homes were characterised by a dedicated manager, good leadership skills, high bed occupancy and a low turnover of staff. Conversely, poorer managed homes were associated with shabby interiors, a chaotic atmosphere, poor relations with relatives and other agencies, and a sense of visible 'abandonment' in residents. Larger chain homes were reputed to benefit from economies of scale, whereas small single homes were 'homely' but lacked resources and adequate management systems. Recommendations from this study included the need for greater access to NHS nursing expertise.

Care home staff have been described as being isolated and excluded from main stream care systems by their different conditions of employment (including pay), and restricted opportunity to meet colleagues in other homes (Davies, 2001). Other authors have stressed the need for inter-agency working due to the increase in dependency of older residents in care homes over time, and a variability in the standards of care that requires a greater need for the co-ordination of health and social care (Bartlett & Burnip, 1999). Of importance to the recent policy emphasis upon inter-agency working, some authors suggest that there is little evidence of the involvement of NHS services by care homes, or the ability of the NHS to meet potential demands created by the uptake of services by homes, or the capacity and role of the independent sector within health and social care services for older people, as a whole (Jacobs & Glendinning, 2001).

5.1.3 Training and education in the care home sector

Several studies and reports have indicated deficits in UK care homes' practices over the past five years indicative of the need for greater education and training. When the RNCC tool was assessed for feasibility and reliability in a small evaluation study of 152 residents (Wild & Ford, 2001), half of their care plans and one quarter of their assessment documentation had not been completed within the preceding four weeks, and were deemed to be inadequate and unreliable for the decision-making underpinning the determination of the residents' registered nursing care needs. The Working Party of the British Diabetic Association (1999) has also drawn attention to several general educational deficiencies in the care of nursing and residential homes' diabetic residents. These include: inadequate medical supervision, care planning and management; inadequate dietary information; inadequate medical knowledge about diabetes; restrictive and routine

practices; and a lack of training opportunities for staff. Furthermore, a recent survey of 695 older people living in care homes and their own homes in one locality provided evidence of poor monitoring and prescribing practices and a higher use of laxatives in the former rather than in the latter location (Fahey *et al.*, 2003).

Residents with mental impairment form an important group whose care requires special skills and training. Meltzer *et al.*, (1997) estimated that approximately 36% of people with moderate or severe cognitive impairment live in institutional care. A survey of 231 residents in Newcastle found that 91% of them had a form of dementia (Margallo-Lana *et al.* 2001), and McDonald *et al.* (2002) found a prevalence in non specialist nursing homes of 74% of the residents surveyed. In a survey of care home providers of care for older people, few areas of lack of staff knowledge or need for training were identified by managers, but a major exception to this was the need for specialist skills and knowledge for residents with dementia (Bartlett & Burnip, 1998). Similarly, in a community study funded by the Alzheimer's Society of 78 nurses from 32 general practices, 91% of the nurses had difficulty talking to patients with dementia, and some three-quarters had difficulty in identifying the first signs of dementia (cited in The Alzheimer's Society Report, 2002: 4.4). Thus the skills to identify and assess the nursing needs of these individuals in care homes would appear to merit particular attention.

Training and education of care home staff in the independent sector is widely recognised to have broader benefits. Links between education and retention of care home staff have been made in a US study where high staff turnover was found to negatively impact upon a home's ability to deliver high quality care (Riggs and Rantz, 2001). In 1998, Bartlett and Burnip concluded from their study of care homes that the following elements are essential to achieving quality care: mandatory training for care staff and continuing education for qualified staff; opportunities for joint learning between the public and private sector; a greater provider or support role in education by local authorities and health authorities; increased emphasis upon outcomes for residents; and adequate funding for homes to achieve all of these. Earlier, in 1997, an English National Board survey of 700 nursing homes (ENB, 1997) had found that residents' autonomy was positively associated with the level of nurses' educational experience, the proportion of staff undertaking education programmes, and the level of staff's contact with education centres.

5.2 MAIN MESSAGES FROM STUDY

The overall aim of our study was to provide a first evaluation of the implementation of NHS funded registered nursing care in care homes in England. Other objectives included providing research evidence on impact on the relationship between the NHS and care homes; any NHS nurse resource implications, including performance and monitoring of RNCC determinations; use of the RNCC tool in the field, including its acceptability and any modifications; perceived consistency of decisions made across a range of bands; RNCC training needs; appeals against RNCC banding decisions, reasons for appeals and their outcomes; and funding for continence promotion aids and specialist equipment. The main messages from our study are presented below, together with suggestions for capitalising on FNC in order to provide future benefits to residents in the care home sector.

5.2.1 The care home sector and bridging the cultural divide

Although the changes associated with NHS funded nursing care had the ostensible aim of stabilising the care home sector and creating greater confidence in its future, implementation of FNC in October 2001 (at the same time as other major organisational changes in the NHS) carried significant risks. From a health service perspective, the main onus of the planning and implementation responsibility very rapidly came to rest with PCTs, the majority of which were new organisations, with several only being established after October 2001. DoH guidance (DoH, 2001f) recognised this to some extent, with health authorities seen as providing a fall back position at first, if required, for RNCC determinations. However, the major changes proposed in *Shifting the Balance of Power* (DoH, 2001a) with the creation of new Strategic Health Authorities that have a significantly different role, meant that these new authorities would not necessarily be able to continue to support the implementation of the NHS FNC policy. Thus, the implementation of FNC might have unforeseen consequences for the wider NHS care system. In particular, unintended consequences might occur at various points such as the acute/ community interface, where residents entering care homes from hospital might be a risk of delay in the hospital discharge process if patients or relatives disagreed about the banding of care.

As described above, the care home sector has historically been isolated from the NHS. Our study found that the vast majority of NHS nurses and care home RNs in England view the relationship between the two sectors as good. Even so, in terms of the introduction of NHS funded nursing care, we found that care home senior nursing staff are less likely than NHS nurses to report that FNC has improved relations between NHS nurses and care homes, resulted in better standards of care for residents, or resulted in financial benefits for care homes. Similarly, although almost three quarters of care home staff report that their overall impression of NHS funded care is that it is fair for residents, only a third consider that the impact of FNC on care homes

is acceptable. Both care home staff and PCT nurses reported that implementation of FNC has extended the administrative burden for care homes and increased the number of closures of homes.

Key conclusions and recommendations:

- Evaluate the impact of RNCC on the nurse's role as directed by the United Kingdom Nursing and Midwifery Council.
- Undertake a comparative study of the impact of FNC as perceived by NHS nurses and nurses working in care homes.
- Identify the causes and effects of cultural barriers between independent sector care home and NHS staff, and a consequential provision of guidelines to overcome these.
- Examine the contribution of FNC to care home closures.

5.2.2 Leadership & FNC roles and responsibilities

Leadership of the new FNC policy initiative had to be developed at a local level because of the rapid transfer of responsibility (including RNCC training, organisation and conduct of determinations, and budgetary management) directly to PCTs. This was because regions (which were originally charged with a leadership role) were being disbanded, and HAs who would have been involved were being replaced by SHAs (whose role in relation to FNC was unclear). Thus, it is not surprising that one year later in 2002 there still remained some lack of clarity in the field, for example, as to who holds the responsibility for continued monitoring and quality assurance of FNC, or for the requirements for ongoing and current (in terms of policy) RNCC training. Furthermore, only one in three PCTs were able to report any SHA involvement in these aspects of FNC by March 2003. We observed a distinct lack of consistency in the role adopted by SHAs in FNC quality assurance, in ensuring good practice across PCTs, and in staff training, although lead nurse appointments with responsibility for more than one PCT were slightly more likely to be able to identify a named SHA individual with involvement in these. It thus appears that monitoring and direction for FNC is missing at a supra-PCT level, for example at SHA level.

Our research also highlights a number of issues associated with the roles and responsibilities of the lead PCT nurse appointments. As originally envisaged by the DoH (DoH, 2001f), there were to be two distinct roles involved in implementation of FNC. These were to be a *nursing home co-ordinator role* (including budget management and complaints) and a *lead nurse role* (including provision of professional nursing advice to care homes, audit of RNCC determinations, and overseeing RN training). A PCT might have two separate staff, or possibly one person combining the two roles. Subsequent guidance (DoH 2002b) indicated that those with lead nurse responsibilities should not undertake RNCC determinations because of potential conflict of interest - or, if they did, that a neighbouring PCT should undertake their auditing role. Our study found that, in fact, nearly half of lead nurses (47%) *were* undertaking *both* determinations *and* audit as late as March 2003. This reinforces the need for external monitoring and direction, preferably with the involvement of SHA nursing staff.

We found that a combined role is present in less than half (41%) of PCTs who responded to our surveys. Nurses with separate roles were more likely to be working across two or more PCTs, and those with a combined role almost all serve only one PCT. These patterns appear to be associated with human resource/ staff budget pressures, with funding of two separate persons apparently most likely to be sustainable across a number of PCTs, presumably due to economies of scale. The 'patch' over which these two individuals work might extend to an area as large as a strategic health authority (i.e. 6 PCTs).

Key conclusions and recommendations:

- Models of leadership and integration of RNCC with other activities need further research.
- Further guidance is needed on the roles and responsibilities of SHAs.
- Clarification is required of the co-ordinator/ lead nurse role at individual PCT level vs separate roles across PCTs.
- Need to review the workloads and responsibilities of those with separate lead nurse and co-ordinator roles from those with combined roles.
- An examination of the consistency of audit processes across PCTs is needed.

5.2.3 Budgets for FNC implementation

The funding of NHS FNC included £100m identified by DoH for the first phase of implementation. This was to cover 42,732 self-funding residents at an average £85 per resident per week, back dated (DoH 2001 l), and equivalent to a total of £94.4m for 6 months cover. When the £6m allocated for the costs of continence products is added, this leaves *no funding* for the staff cost of undertaking determinations, or for general RNCC co-ordination and management. The £584m allocated to PCTs for the period 2003-2004, to cover the estimated 130,264 self funding and LA supported residents (2003e), equates to an average £86.2 per resident per week. At the same time, the original banding levels were raised to high £120, medium £75 and low £40 (from April 2003). The 2003/04 allocation therefore still excludes the cost of determinations (and also of continence products).

Our research has identified that a lack of dedicated staff budgets, to undertake determinations and to co-ordinate FNC at PCT level, has proved a hindrance to optimal implementation, and may affect longer term sustainability. This human resource issue has resulted in community nurses, whose workload is already perceived as high, having to shoulder the responsibility for determinations. As a result, both NHS lead nurses and care home staff identify adverse knock-on effects on the general availability of community nurses. It also appears that lack of a dedicated RNCC staff budget is a reason for the limited use of mental health trained nurses to undertake determinations of residents with mental health impairment, since in some areas these staff, described as already under pressure of work, were not prepared to undertake determinations without payment. This was not the only factor, however, since it is also evident that some lead nurses hold, what is perhaps a misplaced professional value judgement, that non-RMN trained staff can equally well undertake these determinations. There is currently an absence of guidance in this area. Resources for RNCC

training also appear to be constrained. The majority of lead PCT nurses responding to our surveys (over 90%) were not able to identify an RNCC training budget. Findings from our localities study also indicated that training in finance was needed by nurses responsible for budgets, and clearer guidance on who should hold responsibility for both the determination process and payment to residents.

The estimated NHS cost of undertaking RNCC determinations is not negligible. Our research found that approximately one hour of RN time is spent on activities directly associated with a determination; and on average a further two hours per determination are reported to be spent on indirect (e.g. administrative, supervisory) activities within PCTs. Thus, we estimate between £3 and £9 million of NHS time is required to undertake this activity, a mean value of £30,000 per PCT. Although figures were not available from our surveys, this estimate can be compared with the central cost (i.e. nursing home co-ordinator and systems administrator) estimated by one PCT with 600 residents undergoing determinations of £80,000 per annum i.e. £50,000 NHS cost and £30,000 City Council payment agent costs (Meeting of Bristol South and West PCT, November 2002).

Furthermore, most NHS nurses agreed that FNC implementation has also resulted in more administrative time for care home staff. Care homes identified that, on average, their staff spent one hour in support of each determination, resulting in an estimated national cost to care homes of approximately £2.9 million annually. The impact was greater on smaller care homes, with more time per determination being reported. Large nursing chains were able to achieve certain economies of scale by centralising some of the indirect costs (e.g. administrative functions), but for smaller, independent care homes this presumably was not possible. This means that the introduction of FNC has placed additional pressures on the more vulnerable part of the care home sector. This was confirmed by the fact that more than one in three homes considered that the time required was not acceptable, and a similar number stated that more frequent determinations would have major implications for care home staff resources. As pointed out earlier, both PCT nurses and care home staff considered that implementation of FNC had increased the number of closures of care homes.

Once a determination is complete, the process of RNCC payment appears to have been implemented smoothly, although approximately one in five care home managers did identify some problems with the promptness of payments. Hold ups in payment were mainly due to administrative delays, including communication problems and out of area transfers. Virtually no (2%) PCTs considered that lack of resources caused payment delays. PCT nurses reported that any delayed payments were backdated to the home admission date.

Key conclusions and recommendations:

- The efficiency of different models of use of nursing staff for RNCC determinations needs further research.
- A review of real costs to PCTs is needed for the processes involved with RNCC determination including training, travel, time, and administration.
- Consideration needs to be given to whether banding residents is cost effective in terms of NHS staff time spent on determinations.
- Also, whether a single band payment system would benefit care homes by reducing time spent on determinations.
- Greater transparency of FNC funding for training, administration, and other costs is required, i.e. travel, to achieve consistency across PCTs, and the provision of adequate related funding.

5.2.4 Staffing, skill-mix and sustainability

As well as a rapid devolution of full responsibility to PCTs, there is clear evidence from our study that the approach adopted initially in most PCTs to FNC implementation for self-funded residents was primarily task-oriented. Nursing staff focused on completion of tasks by set target dates, and not on establishing sustainable systems (Ford 2001). In reality, some of these target dates were subsequently moved on by the Department of Health, for example determinations for local authority supported residents, presumably because it was judged that they were unattainable. In the meantime many PCTs had initiated strategies and gathered momentum towards meeting the original target dates. For LA supported residents, this was at least partly because the experience of completing RNCC determinations for existing residents had in many PCTs created concern about how they would manage to complete determinations for these other residents by the initial deadline set. That staff met these targets to a large extent suggests that either there was some available capacity in the community system or, more likely, that nursing staff had to re-prioritise normal workload, possibly to its detriment.

As pointed out above, an important factor indirectly influencing the organisation of staffing for FNC in PCTs, appears to have been a lack of clarity about budgets to cover staff time for undertaking determinations. This lack of ring-fenced funding, combined with geographical variations in the level of 'spare capacity' among existing community nursing staff observed in the localities study, meant that PCTs with larger FNC budgets (i.e. those with the largest number of determinations to carry out) were better able to centralise implementation, and that they could adopt a pattern of using fewer nursing staff, whereas other PCTs were using up to 40 RNs to undertake determinations. It also appears that in the second 'steady state' phase (i.e. post April 2002) once the peak of existing self-funded residents had been tackled, although the number of determinations per month carried out by PCTs fell to half the previous level, there was no indication that staffing was being rationalised and fewer, more dedicated nursing staff used. Thus, even with time, the original pattern of working in a PCT appears to have become 'fixed'. In some PCTs the co-ordinator/ lead nurse adopted an extreme, centralised approach and undertook *all* the determinations herself, as was observed in one of the localities studied.

There were some indications, also, that in PCTs where a number of RNs were used, whereas at first G grade nurses were employed to undertake determinations, lower F grade nursing staff are now being trained for this role. This was confirmed in the localities study. Presumably this trend is also linked to pressures on budgets, as well as the opportunity cost of removing more senior staff from other activities, without compensating funding. There is no guidance on the seniority of staff and crucially no guidance regarding the competency required to undertake determinations, although there is acknowledgement by RNs that the process requires *judgement* because the diversity of residents' needs do not always fit the bands' given criteria, as observed by Wild and Ford (2001).

On the one hand, therefore, there appears to be evidence of de-skilling of the determination process itself, with lower grade staff being used. At the same time, there also seems to be evidence of use of senior lead PCT appointments for low skill tasks. For example, lead PCT nurses report that they are responsible for maintenance of determination records, rather than clerical staff. Responsibility for records maintenance was shared with other people in fewer than half PCTs. More positively, the localities study revealed that in both cases, the PCTs were working towards shared FNC databases with Social Services although time-scale for full integration was set at 10 years for one locality. Other sites in the national survey also reported this development.

Finally, from our research it would appear that a particular area of concern is that of determinations for residents with mental impairment. Stakeholders interviewed during stage 1 had raised questions about the appropriateness of the RNCC tool for residents with a mental health condition. In the national surveys, only one third of the PCT respondents indicated that a registered mental nurse would be routinely involved in such determinations. We were unable to gauge the views of RMNs themselves on the RNCC tool in a rigorous manner since only six NHS nurses who responded were mental health trained; those who replied rated the RNCC tool high as a means of establishing correct banding, and rated its ease of use similarly. The localities study confirmed that RMNs were under pressure in terms of workload and, even when trained for RNCC, they were not always deployed. In fact, evidence for one locality indicated that the RN relied upon a care home manager, as an RMN, for some EMI determinations rather than an independent RMN.

Key conclusions and recommendations:

- Guidance is needed on the competencies and level of RN experience required to undertake RNCC determinations
- Guidance, based on further research, is urgently needed on who should be conducting determinations for residents with mental impairment in specialist EMI and non specialist care homes.
- Review of the current RNCC tool is needed to determine whether it adequately reflects the nursing needs of people with mental health impairment.

5.2.5 Targets and delays

In the context of these various pressures, most PCT lead nurses still managed to make good progress in meeting government targets. Nearly nine out of ten PCTs responding to our surveys indicated that all their eligible residents had undergone determinations by March 2002. This figure was confirmed by care homes, although one in ten stated that their self-funding residents had not undergone determination during the required 6 month period. PCTs also reported that 3 month follow-ups of self-funders were up to date in eight out of ten cases. In addition, two-thirds of PCTs had completed all determinations for LA supported residents approximately one month before the (revised) target date for the *commencement* of these determinations.

Interestingly, the PCTs that had not met target dates were not necessarily those with larger numbers of determinations to complete. For existing residents, it may be that completion was linked to available human resources and budgetary pressures, as outlined in section 5.2.4. However, for new admissions, the main cause of delay in completing determinations was reported to be poor communication, rather than a lack of time or staff. The requirement to complete RNCC determinations was not identified by anyone as a cause of delay in transfer to care homes. This does not, however, necessarily prove that RNCC determinations will have no effect, since determinations were rarely being undertaken before admission to a care home. However, lead nurses stated the most common reason for delays to transfer was care home capacity in their PCT. Other factors were cited by very few PCTs.

As originally envisaged, RNCC determinations and SAP were to be rapidly integrated for new residents following the implementation of SAP in April 2002. However, because of delays in the introduction of SAP, by March 2003 only a quarter of lead nurses said that it had been introduced in their PCT, and only one in ten of these said that SAP was being undertaken at the same time as the determination for FNC. Fewer than half of PCTs even had a system in place for this. However, most PCTs reported that determinations for new admissions were completed within 14 days following admission to the care home. Consultation about the implementation of SAP was still on-going when our surveys were undertaken, and this only ended on 29th August 2003. Although evidence from the localities study suggested that links were being considered between the two processes, we are unable to comment on the reality of joint conduct of RNCC determinations and SAP.

Key conclusions and recommendations:

- Research is needed into models of integration of RNCC with SAP.
- Cross cultural research is required between the independent sector with NHS and Social Services to elucidate issues for improvement in communication.

5.2.6 RNCC tool and determination process

In the context within which FNC has been introduced, the RNCC tool appears to be generally acceptable to staff. PCT lead nurses and care home staff both rated the ability of the RNCC tool to achieve the correct banding as high, although RNs undertaking determinations demonstrated lower certainty over this. Thus, confidence in use of the tool is high, while at the same time it is acknowledged that it has a limited 'scientific' basis and that judgement is required in its use. RNs identified that additional information may well be needed as well as that from the RNCC tool; these nurses mainly added assessment and history taking sheets. At the same time, nearly one in two lead PCT nurses reported that adaptations had been made to the RNCC tool documentation, although there is no consistency in these. Adaptations to documentation were agreed at PCT level in fewer than half of cases, and RNs as well as co-ordinators/ lead nurses contributed to these additions. Finally, all three staff groups consider that agreement by residents/ relatives with final bandings is high, and this would appear to be confirmed by the very low levels of appeals, although the very low level of knowledge that relatives have should also be taken into account.

In terms of fitness for purpose of the RNCC tool, or consistency across determinations, it was more difficult to draw conclusions. We observed a trend towards higher bandings across the two FNC rounds as new resident admissions underwent determination. Qualitative evidence supported a probable link to the changing 'mix' of patients, with new admissions requiring greater RN care than existing residents, especially if admitted from hospital. Two out of three care home managers also agreed that, in their experience, a new resident generally improved after admission and would then fall into a lower banding. Any issues associated with such changes in banding over time for residents and their relatives could not be explored fully in this study. For self-funding residents, it was reported that the choice of care home might be influenced by the banding decision. However, during our study period determinations were still mostly being conducted after admission to care homes, because SAP had not been fully implemented (see section 5.2.5). For those care homes that reported re-determinations undertaken to accommodate changes in residents' health status, most care homes said that it was at their request. In the localities study, care home managers also identified that the lowest banding level was insufficient, especially if a home had a significant number of residents on the lowest band.

Because of the original assumption that SAP for new residents would be implemented from April 2002, it had been assumed that the RNs undertaking determinations would be able to draw on this assessment information (2001i). However, with the delays in implementation of SAP, RNs had to resort to other sources of information, including scrutiny of care home notes, observation of the resident, and discussion with care home nursing staff.

The vast majority (almost three-quarters) of lead nurses reported that in their PCT care home documentation plus a meeting with the resident were *always* used to make decisions on banding, and this was confirmed by RNs. Remaining PCTs admitted that they sometimes use documentation alone. But, a few PCTs reported that they *always use only documentation*, and therefore presumably exclude the resident and the care home staff known to the resident. This picture on use of documentation was confirmed by care homes' senior nursing staff responses in the stage 1 survey.

The inclusion of care home staff and relatives in the determination process appears to vary, depending on whether or not the determination is carried out pre-admission. Over half of care homes reported that, for determinations conducted in their home, their staff are always involved. However, two thirds indicated that relatives are never, or not very often, involved. This observation is presumably primarily based on experience of determinations undertaken for the bulk of existing residents in their home. In contrast, for new admissions it seems that potential residents and their relatives are much more likely to be involved, with up to two thirds of PCTs indicating that this is usually the case. But, as might be expected, care home staff are less likely to be involved in the determination process for new admissions. The pattern that emerges is one of social services and hospital or primary care nursing staff involvement in the first determination of new residents prior to admission, together with their relatives. After that, the re-determinations carried out in care homes are less likely to involve relatives and much more likely to involve care home nursing staff. In order to achieve a person-centred approach (NSF for Older People, DoH 2001b), determinations should be undertaken with direct involvement of the older person, significant others and the nurse best known to the individual concerned. Thus, although determinations for new admissions come closest to this, those undertaken in care homes do not. Guidelines for SAP specify the involvement of residents and relatives, but there are no similar guidelines for conduct of RNCC determinations. Thus, local guidance may differ across the country, and it would appear that there is a need for renewed emphasis from the DoH regarding the involvement of older people and their families, bearing in mind that all registered nurse care needs reviews carried out within 3 months of a first determination, and subsequent annual re-determinations, will be carried out in care homes.

The professionals missing from any involvement in determinations or re-determinations, even for new residents, are medical staff (either GPs or hospital geriatricians). A liaison nurse or a community nurse was most likely to be involved for new admissions from hospital or own home respectively. Presumably it is assumed that the nurse will be able to provide all the relevant clinical details for RNCC (and SAP), without any involvement from doctors.

Finally, once a determination is complete, access to determination records is variable depending on the PCT. RNs are the staff most likely to have access, although just over one third of PCTs state that they do not. Only one in two PCTs report that residents have access to their determination record, and a similar proportion that care home managers do.

Key conclusions and recommendations:

- Need to review efficacy and consistency of RNCC decision-making without recourse to resident, i.e. based upon documentation with decisions made which involve resident/ relative or named care home nurse.
- Standardised care home documentation to support FNC.
- Guidelines are required to differentiate between RNCC higher band with continuing care criteria, to attain national consistency of decision-making.
- As SAP is used by multi-agencies, in contrast with the RNCC determination which is nurse-led, there is a need for guidance in adopting a common use of language across both tools to attain comprehension by all professionals. This would also benefit residents, relatives and care home staff known to the resident, all of who were observed to have had some difficulty in understanding FNC.
- A review of application and outcome of RNCC is needed across several SHAs to determine equity of application and consistency.
- A review of process for access to records, particularly by residents and relatives is required.
- Views of service users requirements for information about FNC and the part that care home staff might play in providing this information would be helpful.
- Clearer guidelines are needed re: professional advocacy and resident /relatives/ and care home staff responsibilities and involvement in RNCC determinations.
- Further research needs to be undertaken on the impact of RNCC on the delivery of NSF standard on person centred care.

5.2.7 Training

In the majority of PCTs, initial training of RNs was not considered to be an issue. Survey responses from co-ordinators/ lead nurses and the majority of RNs indicated that training had been introduced smoothly in most PCTs. However, it was clear that the speed of implementation of FNC, combined with other organisational changes occurring at the same time, did impede training as originally planned for some lead nurses and co-ordinators. More worryingly there were a number of RNs who were carrying out RNCC determinations in phase 1, and continuing to undertake determinations in phase 2, with no formal training. This may be linked to the absence of training budgets or funded training time, and pressure upon staff in order to meet targets.

From responses to our surveys, it would appear that thought still has to be given to further training for NHS FNC. It was pointed out that little consideration had been given to ongoing training and sharing of experiences (organisational learning). Also, even for RNs whose determination bandings are changed on appeal, fewer than ten per cent of PCTs say that re-training would 'sometimes' take place. Another key area of training need, highlighted by NHS nurses, is the extension of training to care homes. PCT nurses see that this would help care homes understand the RNCC process, and also improve their documentation. Senior nursing staff in care homes similarly identify a need for more information about

the RNCC tool as one of the two most important requirements to improve the RNCC determination process. At the same time, care home RNs were of the opinion that NHS staff do not appreciate their existing expertise or their possible contribution to the determination process, another aspect of the need to bridge the cultural divide.

Key conclusions and recommendations:

- Updated training for RNCC was identified as a priority now that experience had been gained. The best way of delivering such training needs to be established.
- The provision of ongoing and updated determination training for NHS RNs needs consideration, in particular where lower grade RNs are to be involved.
- FNC training for independent sector homes to enable them to increase support to the RNCC determination processes.
- Research to establish the quality of care homes' documentation contribution to RNCC determinations and to identify where improvement is required.
- Cross cultural research and training to reduce cultural barriers between care homes and NHS.

5.2.8 Quality assurance, appeals and informal reviews

Although reported confidence in the RNCC tool was high, almost two thirds of senior nursing staff in care homes either did not know how NHS quality assurance of determinations is managed or thought that it is not undertaken at all. This did not depend on the type of care home (member of large chain or single independent home). The main quality assurance method used by PCTs is spot checks of RN bandings, often in combination with monthly audit using the DoH audit tool (DoH 2002c). All PCT nurses reported that they liaise with other PCTs regarding quality assurance for RNCC bandings, and approximately one in four say they include members of the independent sector in their quality assurance process. However, as pointed out in section 5.2.2, there is evidence that nearly half of lead nurses are undertaking both audit and determinations, against the draft guidance issued by the Department of Health (DoH 2002b).

Once a determination is complete, nearly half of residents and relatives are informed of outcome at the time. One third of care homes' staff report that their residents are informed subsequently in writing, with relatives slightly more likely to be informed in writing than residents; twenty per cent of residents are informed verbally. In the localities study, service users interviewed were generally not well informed about the RNCC bandings and the implication this might have. This is problematic for new residents, as choice of home is likely to be made before banding decisions are known. Furthermore, dependency will increase with advancing age and eventually give rise to some type of nursing need.

Survey data in the two time periods showed low levels of appeals. Appeals were more likely to result in a higher band than originally determined. This is consistent with the two main reasons for appeals which are reported to be either that the banding is too low, or that there is a desire to move to continuing care funding. Both the number of appeals and the number of PCTs reporting them decreased over the two time periods.

But, after taking into account the fact that the number of determinations fell over the two time periods, there was actually a slight increase in the likelihood of a determination resulting in an appeal in the later time period.

Although our initial interviews with key stakeholders had identified that the level of appeals was low, interviewees pointed out that they thought that *informal* reviews of RNCC outcomes were taking place at a local level. Our national surveys subsequently identified that the numbers of such informal reviews is also small. However, as a percentage of determinations undertaken they can still represent up to 89% of determinations carried out in some PCTs, even though the actual number of determinations is low (<20).

As well as differing in their formality, appeals and reviews are also reported to differ in other respects. Appeals are generally prompted by relatives, whereas, reviews are predominantly instigated as a result of a change in the resident's health status and requested by the care home.

Systems for appeal are not yet established in all PCTs. Only six out of ten PCT lead nurses reported that their PCT has a formal appeals body or committee, with a further small number indicating that their SHA is beginning to set up an appeals process. This is presumably because of the small numbers of appeals. Following an appeal, only one third of PCTs say that re-determination would be undertaken by a nurse from another PCT. In half of PCTs the responsibility lies with the co-ordinator or lead nurse in the home PCT, which would appear to be counter to good practice.

PCTs all disseminate the results of appeals to both residents and their relatives, but only one third communicate results to care homes. Thus, although there is consistency in so far as residents and relatives are concerned, there is less consistency in terms of whether care homes are informed. The responsibility for dissemination once again lies principally with the co-ordinator or lead nurse.

Key conclusions and recommendations:

- To establish whether appeals are not generally occurring because residents or relatives are unaware that appeals can be made against banding decisions.
- A review of audit mechanisms for RNCC determinations and what constitutes either informal review or formal appeal is needed to ensure greater national consistency and avoid a potential for under-utilisation of these mechanisms.

5.2.9 Relatives' and residents' perspective

The localities study showed that relatives are poorly informed about FNC in spite of national publicity and information available on the Internet. It is not known whether residents themselves are aware of the purpose of the determination meeting, as access to residents did not prove feasible in this study. Only chance remarks by care home staff alerted relatives to the possibility of making an appeal for example, and relatives were largely unaware that they could be present during determination. This is especially important if residents are suffering from dementia. However, there may be practical problems in agreeing a definite day/ time for the determination which is suitable for all participants. There is also some evidence of paternalism on the part of care home staff, with decisions made about the appropriateness of inviting relatives by care home staff; and dependency by relatives, many of whom appear to leave everything to the care home manager to pursue and sort out.

From the relatives' viewpoint, the timing of appeals needs to be substantially shortened as there were instances of the resident having died before the appeal was heard. This was most upsetting for relatives, adding to their sorrow at the bereavement.

In spite of the lack of information, all interviewees in the localities study expressed gratitude and satisfaction with the care which their relative received.

Key conclusions and recommendations:

- Survey the experiences of older people in accessing funded nursing/and/or continuing care funding.
- Further research is needed into provision of information to residents and relatives, and how they might play a more active role in decision making.

5.2.10 Continence aids and specialist equipment

Incontinence is a key issue for care homes, not only because many residents suffer from it, but because it commands high resource if poorly managed. In 1998 it was estimated that the NHS spent more than £120 million per annum on absorbent products (Pollock, 1998) with costs to the average primary care organisation in the UK estimated at about £737,000 per annum (Continence Foundation, 2000). A team approach and appropriate referral have been associated with effective management of incontinence (Rigby, 2001), and improvement in training and assessment have been associated with reduced cost (Roe *et al* , 1996). The initial funding of NHS FNC included £6m identified by DoH to cover the costs of continence products over a 6 month period, an average of £5.40 per resident per week (DoH 2001 1).

In terms of specialist equipment, specialist nursing and rehabilitation, the involvement of care homes is acknowledged to be variable. Rehabilitation is central to the success of The NHS Plan (DoH, 2000a) and the National Service Framework for Older People (DoH, 2001b) and has been included in definitions of

intermediate care (Steiner, 1997; Oxford Health Authority 1999). At the same time, reviews concerned with rehabilitation in the health and social care sectors (including the independent sector) have concluded that there has been a decrease in rehabilitation services, with older people being particularly disadvantaged (Sinclair & Dickinson, 1998; Nocon & Baldwin 1998). In a survey of homes in one urban HA, only 6% of residents had been assessed by a physiotherapist, and a quarter of the homes had made no referral to either an NHS or private physiotherapy service in the preceding year (O'Dea *et al*, 2000). A survey of homes in one urban health authority found no use of specialist nursing services in the preceding year (Parker *et al*, 2001), and in another single HA survey in the same city, the use of specialist nursing was described as variable with the greatest uptake being for continence advice (O'Dea *et al*, 2000).

The introduction of continence and equipment assessments therefore offered potential benefits to care home and their residents. However, several of the care home stakeholders interviewed in stage 1 of our study, particularly those from the larger chains, thought that their existing systems and expertise were not acknowledged by NHS staff. Interviews with regional and SHA stakeholders also suggested that geographical location could prevent access to preferred continence products for some homes, and limit previous choice. Widespread constraints on choice were confirmed by our national surveys, with only one third of PCT lead nurses reporting that they pay a fee to the home, allowing choice of continence aid, and the remainder simply provide a standard product. PCT stakeholders indicated that they were able to spend about £5 per week for an incontinent resident, which fits with the £5.40 figure above. Some raised concerns about disparities between self-funders and others, that might lead to self-funding residents being penalised. Other issues raised by care homes in stage 1 interviews included the lack of care home staff inclusion in continence assessments, (perceived to be progressing slowly); and the practical problem of storage following bulk deliver of continence products.

Although a majority of PCT stakeholders indicated that planning was in progress in late 2002 for continence assessments, this had not yet been implemented in most areas. These interview findings were confirmed by the stage 1 national survey, where at most approximately one third of residents with a completed RNCC determination had also had a continence assessment. In fact, nearly four out of ten PCTs reported that they had undertaken no continence assessments, once again mainly those with fewer residents. Progress with implementing continence assessments was therefore much slower than for RNCC determinations, with care homes presumably bearing the cost of these products in the interim. The NHS staff used to undertake continence assessments were also variable, with some PCTs assuming that the RNs undertaking determinations would also carry out continence assessments, whilst others were referring residents to a specialist continence advisor. A few SHA stakeholders reported the setting up of joint funding initiatives by PCTs with Social Services in the area of continence aids, and of a systematic profiling of needs.

There was a consistent relationship between the outcome of continence assessments and RNCC banding levels. PCT lead nurses in the stage 1 survey reported that none of their residents banded low required continence aids, whereas up to three quarters of the medium and high band residents did.

There were a large number of issues reported in stage 1 stakeholder interviews in relation to specialist equipment assessments. These included: a lack of clarity about what equipment was included, and who held the supply responsibility; the increased burden of cost for equipment; and the need to involve care homes in decision-making. There were perceived to be cost containment pressures, and particular difficulties were anticipated for smaller care homes. Both PCT and care home stakeholders reported that, where there was cross-working with Social Services for continence and equipment provision, this was viewed positively.

A large proportion of PCTs reported that they had undertaken no specialist equipment assessments by March 2002, by which time the majority of self-funding residents had undergone RNCC determination and 3-month re-assessment. Where equipment assessments were being performed, these were usually undertaken by community nurses, although a quarter of PCTs reported that residents were also assessed by independent sector nurses and social service staff. The main type of specialist equipment need identified was linked to prevention of pressure sores e.g. specialist mattresses. Not only were specialist equipment assessments slow to get underway, there also appeared to be very limited specialist nurse input (<5% of PCTs), such as tissue viability nurses.

Once again, there was a pattern associated with equipment assessment outcomes and RNCC banding levels. No residents in the low band were reported to need specialist equipment, whereas up to 100% of residents in the medium and high band did.

Key conclusions and recommendations:

- The processes of supply for continence aids and equipment need to be standardised to ensure equality of access across PCTs and in the case of continence products, to ensure person-centred choice.
- Progress with equipment assessments needs monitoring, together with examination of variations in terms of what equipment is included, and who holds the supply responsibility.
- Cross-working between PCTs and Social Services for continence and equipment provision should be encouraged.

5.2.11 Capitalising on FNC

The opportunity exists to use the introduction of FNC as a means of enabling the NHS, local government, and the independent sector to work collaboratively to improve the quality of care and access to health and other services for care home residents. This has not yet been adequately capitalised on in England, partly due to the speed of implementation and also because of the absence of funded time for implementation. Capitalising on FNC will require acknowledgement of the time staff in both sectors spend on organising and

conducting determinations, and the potential to use these regular visits to care homes to develop closer working relations with independent sector staff, leading to benefits for both sectors.

It is clear from policy that modern health and social care has an emphasis upon partnership and interdisciplinary ways of working. The Audit Commission's (1998) definition of partnership is either a joint working arrangement where partners are independent bodies who co-operate by the creation of a new organisation structure, or a process that plans and implements a joint programme through the sharing of relevant information, risks and rewards towards the achievement of the same goal. In a recent policy review by the King's Fund (Banks 2002) of partnership working between the NHS and local government, although positive signs of progress were reported, major challenges ahead were identified, including: the question of local sustainability in face of high national political pressure; the effects of continuing reorganisation; inhibitors to cultural change across all levels of the organisation (including underdeveloped support systems, staff shortages, inadequate training for change managers, and different professional perspectives which impede relationships); and an integration limited to health and social services with the *exclusion* of a wider range of local government services and the *independent sector*. This critique applies equally to our observations of NHS funded nursing care, as exemplified in its early stages. Our findings also highlight the importance of *developing mutual understanding* in the practice of assessment and provision of care, and implementation of the RNCC determination contributes to this process. Within an overarching philosophy of multi-agency working, there is an ongoing need for NHS nurses to consider their contribution to the continuing health care of older people in the NHS and the independent sector (Ford, 1995; UKCC, 1997).

An important challenge posed by the introduction of the RNCC determination is how to achieve the person-centred approach proposed within the National Service Framework for Older People (DoH 2001b) whilst practitioners are at the same time working within the context of a fiscal and performance target driven culture. Current policy guidance on the identification of Registered Nursing need and the SAP encourages practitioners to focus on the needs of the individual, yet at the same time, refers to ensuring consistency with local agency or local authority priorities, an issue previously highlighted by Nolan and Caldock (1996). More thought needs to be given to the proposed integration of SAP and RNCC determinations, and optimum relationship between the two in the field.

The idea of people having just one assessment of their health or social care needs, rather than being subjected to many and various assessments and checks is recommended in the *National Service Frameworks (NSFs)* e.g. *NSF for Older People* (Department of Health, 2001 b); *NSF Mental Health* (Department of Health, 1999); *NSF Coronary Heart Disease* (Department of Health, 2000). These NSFs incorporate targets for health and social care agencies to meet as part of the provision for improving the nation's health (see the government White Paper, *Saving Lives: Our Healthier Nation*, 1999). These changes have come about due to the government's commitment to reform and modernise the NHS (*New*

NHS: Modern, Dependable, 1997) and the Social Services system with a similar White Paper (*Modernising Social Services*, 1998). Section 31 of the Health Act (1999) also allows for the NHS and local authorities to pool budgets for the better organisation of locally delivered care (Glendinning, Hardy, Hudson and Young, 2002a, 2002b).

The provision of appropriate clinical care for residents will include medical, as well as registered nursing care. The two are closely related in care homes (as in other settings) in terms of the final quality of care provided for older people and other residents. It has been reported that, despite the complex medical needs of older people in care homes, there is a lack of clarity and a variability in meeting the medical needs of older residents (Jacobs & Glendinning, 2001). It has also been indicated by homes' staff and general practitioners, that the nature of medical care required by many older people is more specialised than can be met by the service provided by GPs (Legge, 1999). However, medical care provision to care homes is variable, and the opportunity to use the introduction of FNC as a means of enabling improvement has barely been addressed to date, never mind capitalised on.

In terms of medical care, FNC guidance from the Department of Health (DoH 2001c, DoH 2003c) does not specify a role for GPs in decision-making for RNCC determinations and banding, although older people's medical needs will in turn have implications for the registered nurse care requirement for some residents e.g. medication review. The role of the GP would also seem crucial to accurate decision-making in determining differences in health status between residents allocated to the NHS RNCC high band with those designated as requiring NHS continuing care funding. This has formed a major issue raised by the Health Service Ombudsman (2003), with a recommendation for greater clarity in terms of eligibility criteria for FNC and the distinctions between specialist and general health care, health and social care, and the care provided by registered nurses as opposed to that provided by others.

Medical care provision is at present patchy. A survey of 49 homes in one urban HA revealed that only one home had the involvement of a local geriatrician, and few residents were registered with a general practitioner of their choice (Janzon, 2000). In one census of care home admissions in an urban locality, one quarter of the homes reported difficulties in registering residents with a GP of their choice, and problems arose for short-stay respite residents seeking to obtaining temporary GP cover. In another survey of homes run by charitable, voluntary and benevolent organisations (VOICES/ACO/OBFA, 2001), one third of the homes were reported as paying a retainer fee to GPs that was over and above the normal NHS GP fees and allowances. Guidance for FNC (DoH 2001g) states that a resident should be registered with a local (to the home) GP in order 'that they can have access to the full range of NHS services that are, and must be, free for patients'. At the same time, a large sized care home within a locality can make a major demand upon the service capacity of the nearest GP practice (Glendinning &

Lloyd 1998). Thus, access to improved clinical care for residents may be constrained by the medical care available locally and the extent of proactive agent role adopted by GPs on behalf of the resident patient.

The Department of Health has recently issued guidance to care home managers on GP services for residents (DoH, 2003f), and recognises that it may prove *‘unclear to those without intimate knowledge of the NHS where the line is drawn between what a GP provides as part of the NHS contract and what constitutes private practice.’* However, in contrast with the expectation implied in the above studies, the guidance states that although UK residents are entitled to be treated by a doctor, it may not be possible to register with a GP of their choice. Among the services which are not considered to be part of the GP’s NHS contract are the management of patients with mobility problems, or infection control, or the safe management and control of medicines. This places residents in care homes and their nursing staff in a difficult position when it comes to improving care, developing a rehabilitation function, or drawing on NHS services. It can be argued that, if these resident were in hospital, all of these aspects would be a part of the medical care offered.

There is the opportunity through FNC to consider a more holistic approach to the provision of clinical care required by care home residents (i.e. not only nursing care, but also medical, physiotherapy, OT, optician, chiropodist, hearing, and dental care), and how this can best be provided in a timely manner. This would require the recognition and promotion of FNC as a meaningful point of entry for NHS professionals into care homes, to which they can act as a source of additional expertise and support. Future developments might also include the provision of centralised support (especially for non-chain independent care homes) through the PCT lead nurse appointments. This might include support in areas not considered part of the GP’s NHS contract, such as the management of patients with mobility problems and the safe management and control of medicines, or provision of key management support, for example a centralise bed bureau service. There is also a need to support a more speedy integration of NHS and Social Services databases as a means of pulling together information (discharge information, FNC, SAP and Social Services assessments) as a basis for new ways of interagency working.

The inclusion of older people in their care is also a requirement of the NSF for Older People (DoH 2001 b). Furthermore in the same document the abolition of ageism was called for. Thus, the observed paternalistic attitudes of staff towards older residents and relatives in the localities study would seem to be at odds with these directives. Research and guidance needs to be focused upon these issues as well, and the efficacy of processes and materials for information-giving. However, it must be said that the time required for information giving to residents and relatives concerning FNC and determination outcomes would undoubtedly increase the associated time and workload from that currently deployed and this in turn would increase costs. For local authority supported residents, it may also be questionable whether the same information giving process is required.

Finally, we would also suggest the need for a comparative review of the costs and benefits of FNC in England with related evidence concerning the funded nursing systems in Scotland and Wales, to establish if the former provides more or less value for money. This will be linked to realisation of the potential benefits outlined above, associated with the introduction of RNCC and SAP and the requirement for local NHS nursing staff to enter care homes regularly, offering them the opportunity to provide expertise and support in a non-threatening manner to care home nursing staff, and enabling the development of local partnerships. Consideration should also be given to an examination of the implications of RNCC determination outcomes at the care home level and associated skill mix in relation to the population in a care home. For example, small homes or those with residents given low RNCC nursing care banding may still require a basic level of RN staffing cover which is above the total hours computed. Other homes may have residents with nursing care needs identified, perhaps for individuals whose dependency has increased with advancing age and given rise to increased health care need, but may not currently employ an RN. If appropriate care cannot be provided this will require that the resident be moved. The link between RNCC determination outcomes and skill-mix in care homes requires further study.

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ANNEX 1

KEY STAKEHOLDER INTERVIEWS: QUESTION GUIDE

:

- Respondents' role and responsibilities.
- Number of care homes in Region/ SHA/ PCT.
- Named contacts for NHS Funded nursing care in Region/ SHA/ PCT.
- Named contact for appeals.
- Contact names for PCT lead nurses for NHS FNC.
- Activity data on determinations.
- Number of care home residents in Region/ SHA/ PCT.
- Number requiring continence aids and specialist equipment.
- Resources for training lead nurses.
- Nurse grade for carrying out determinations.
- Comments re: use of RNCC tool.
- Triggers for appeals against RNCC decisions.
- Perceptions of relationships with care homes.
- Any effect on viability of care homes.
- Suggestions for improvement of the process.
- Issues and challenges.

ANNEX 2 – 8 (SEE SEPARATE DOCUMENT)

ANNEX 9

LOCALITY STUDY INTERVIEW QUESTION GUIDE

Lead nurse, RN

- Can you tell me what your views are on the introduction of RNCC determination?
- Is it feasible that only RNs should carry out RNCC determinations?
- Is it practicable that only appropriately registered nursing staff carry out determinations? (e.g. for patients with dementia or mental health needs)
- What role do you think lead nurses should be undertaking? E.g. auditing and training role only (DoH objectives)
- Who is involved in auditing RNCC determinations?
- How is recruitment and retention of RNCC trained staff managed in the community and the local acute trust?
- If other staff carry out determinations how is that managed?

Nursing home co-ordinator, Lead nurse, RN

- **Do you know how the development of SAP is progressing?**

Finance manager, Care home manager

- Are you aware of any health and social care joint pooling of funding systems?
- What kind of contract models for support and administration of LA funded residents are there to ensure continuity of care?

Finance manager, Lead nurse, RN

- Could you tell me about any resource implications for PCTs of employing appropriately trained RNs to carry out determinations?
- Could you tell me about the implications for funding when a care home resident is admitted to hospital e.g. bed holding, maintenance funds to care home from PCT.
- What systems are in place for monitoring care home contracts? (e.g. monitoring of frequency of fee increases/ by national care standards commission (NCSC))
- Are there systems in place to avoid duplication of payments?
- Are there any problems with the payment systems for determinations?
- Can you suggest anything which might improve the payment system?
- What are your views about the PCT allocation of funding for NHS Funded registered nursing care?
- Can you see any advantages/disadvantages of funding based on resident's GP registration?

- Would you see RNCC funding is an addition to previous resources?
- Do you think it is means of raising standards of care in care homes?
- How are out of area contracting arrangements managed?

Care home manager

- Can you tell me what you think about the introduction of RNCC funding?
- What kind of impact on homes has the process of carrying out determinations had on you organisation and staff?
- Has it had any implications for the management of fees by care homes?
- Could you tell me about your system for addressing any resident's complaints about fees?

Nursing home co-ordinator, Lead nurse, RN's finance manager, Care home manager

- How do you think determinations will be managed in the future?
- Do you have recommendations or views for improving the RNCC determination system?
- CAN YOU THINK OF ANY EXAMPLES WHICH YOU CONSIDER TO BE GOOD PRACTICE?
- Can you make any recommendations for quality monitoring of the processes involved in determination?
- Can you make any recommendations about quality monitoring of nursing care in care homes?
- Can you identify any positive outcomes since the introduction of NHS funded Registered Nursing care?
- Can you identify any negative outcomes since the introduction of NHS funded Registered Nursing care?
- Have any challenges arisen for professionals in working relationships since the introduction of NHS funded Registered Nursing care? e.g. with multi-disciplinary teams, social services and care home staff .
- Can you make any recommendations for good and meaningful ways of working for professionals?

ANNEX 10

TABLE 4.4: CONTENT ANALYSIS OF DATA FROM TELEPHONE INTERVIEWS FROM STAGE THREE –CASE STUDIES IN TWO LOCATIONS

Mapping of themes from telephone conversations to IPA super-ordinate categories / identified themes

Super-ordinate category & identified theme / Respondent	DETERMINATION Aware of?	DETERMINATION Present at determination?	DETERMINATION Funding / finance	DETERMINATION Appeals etc.	CARE Quality of care / equipment	CARE Respondents' voices	COMMUNICATION Advocacy / lack of knowledge
Interview 13 Son of resident (his mother) <i>interviewee 19</i>	Not heard of determination "We had a letter saying there will be changes [...] I have never heard of any determination or assessment of registered nursing care that mother needs. I would not know if mother has had anything like that"	Not mentioned - see Awareness of determination	Mother paid for by ss. "They (home) have her pension and she only has about £15 weekly for her personal use"	Not mentioned / not aware	Matron might be able to tell you (i.e. about determination funding) She is very kind [...] We are very happy with how mother is cared for"	Noticeably absent - expressed passivity & gratitude	Not told - although did receive letter (not communication he understood) "I didn't take much notice of this"
Interview 14 Daughter of resident (her mother) <i>interviewee 20</i>	"I am not aware of any Registered Nursing Care determination (or assessment) or involvement with NHS staff in care home"	"I have not been asked to attend or been notified of a determination / assessment that mother had to have"	"I applied for a nursing allowance because of the high cost. Matron organised this for us and now we have some financial support from the health service. Matron has been very helpful. I think it's called a 'high banding' amount that we get help with but I'm not sure."	Not mentioned / not aware	Matron has been very helpful. Matron is very helpful and kind to the residents. Standard has been good since admission"	Noticeably absent - expressed passivity & gratitude	"I have had no letter or notice about NHS funded nursing care or any kind of assessment for mother" [Daughter had never heard of NHS funded initiative or seen any literature]
Interview 15 Daughter of resident (mother of 94) <i>interviewee 21</i>	"I have heard of NHS funded nursing car but have not really read about it"	"I have not met with any NHS nurse in the care home"	"I don't know of any assessment or determination but Matron advised me that some refunding would be available and sorted it out for us. We have had our bill reduced and it is very helpful. It was very good of her"	Not mentioned / not aware	"We no longer have to pay for incontinence pads as the home now supply these. It is a help to us" "Mother's care is excellent since she went into the home. They are very good."	Noticeably absent - expressed passivity & gratitude	"I don't know of any assessment or determination but Matron advised me that some refunding would be available and sorted it out for us."

Super-ordinate category & identified theme / Respondent	DETERMINATION Aware of?	DETERMINATION Present at determination?	DETERMINATION Funding / finance	DETERMINATION Appeals etc.	CARE Quality of care / equipment	CARE Respondents' voices	COMMUNICATION Advocacy / lack of knowledge
Interview 16 Daughter of resident (mother, aged 78 - admission arranged by ss direct from hospital) <i>interviewee 22</i>	"I have never heard of NHS funded registered nursing care - no I've never read anything like that"	Not mentioned - see Awareness of determination	"They have her pension and her personal pension and she has a very small personal amount for her little things she needs" "Matron has mentioned something about a new system of payment starting in October 2003 but says it will not make any difference as the LA is supporting mother. She doesn't have any savings"	Not mentioned / not aware	"She is well looked after and the staff are kind. I think she is happy there you know."	Noticeably absent - expressed passivity & gratitude	"No I've never read about anything like that. Matron has mentioned something about a new system..."
Interview 17 Husband of resident (wife, aged 79, suffering with dementia) <i>interviewee 23</i>	"I have never heard or read about NHS funded registered nursing care. Does that mean it is the health service that pays for the home? The LA pays for my wife when the social services people saw her"	"I haven't been told of any assessment or never been invited to come to any meeting about my wife - but the social services saw to all that"	"They take her pension but her care is free. They give her everything she needs"	Not mentioned / not aware	"The nurses are good to her. She doesn't need any special equipment. They look after her well. It is a relief to me. I am happy with the care at the home. They are kind."	Expressed passivity & gratitude - could it be exhaustion and relief for this husband? He is no longer young himself - sense of relieve that care for his wife no longer rests solely with him? "I try to go and see her every single day. [...] I keep going in because it is better for her to see me every day. You know? I think it helps but it is hard for me as I am not well and the walk there is very difficult for me every day. I have my son at home and he is a help to me. We do our best to help. [...]" "It is a relief to me"	"I haven't been told of any assessment or never been invited to come to any meeting about my wife - but the social services saw to all that"

TABLE 4.5: IN-DEPTH INTERVIEW ANALYSIS: *Identification of categories and main themes identified from interview data***Int = Interviewee (allocated numbers for anonymity) one = PCT location One****two = PCT location Two**

Super-ordinate category / Location	Identified theme	Int 1 one	Int 2 one	Int 3 one	Int 4 one	Int 5 one	Int 6 one	Int 7 one	Int 8 one	Int 9 one	Int 10 one	Int 11 one	Int 12 two	Int 13 two	Int 14 two	Int 15 two	Int 16 two	Int 17 two
DETERMINATION	Funding	3	3			3	3	3	3						3	3	3	3
DETERMINATION	Process / time required	3	3	3	3	3	3		3								3	
DETERMINATION	Relatives' & carers' care needs & concerns	3	3			3	3	3	3	3	3	3				3		3
DETERMINATION	Quality / consistency / accountability / tool as nursing audit	3	3			3	3		3	3			3	3				
DETERMINATION	Appeals / banding decisions	3				3		3	3				3	3				3
DETERMINATION	Documentation / paperwork & administration	3				3	3		3	3					3		3	
DETERMINATION	Continence / equipment	3	3	3	3	3	3	3	3						3	3		3
CARE	Quality of care / values / older people	3	3	3	3	3	3	3	3	3	3		3	3			3	
CARE	Mental health Dementia, loss & bereavement. Learning disabilities	3	3			3	3	3	3	3	3	3	3	3		3	3	3

ANNEX 10

CARE	Discharge / barriers to discharge	3	3	3	3	3			3									
CARE	Respondents' voices / narratives	3				3	3	3	3				3	3		3		
CARE	Working relationships / team working / training	3	3	3	3	3	3		3				3	3				
CARE	Different models / caring role / nursing role / advocacy / compassion	3	3			3	3	3	3	3	3	3				3	3	
CHANGE	Change process	3				3		3	3	3	3	3	3	3		3	3	
CHANGE	Stress, frustration, anxiety	3		3	3			3					3	3	3	3	3	3
CHANGE	Uncertainty & doubt	3	3	3	3	3	3	3	3	3	3	3			3	3	3	
CHANGE	Challenges / drivers & barriers	3		3	3	3	3	3	3	3	3	3			3	3		
CHANGE	Coping strategies	3						3	3	3	3	3						
INTER-AGENCY WORKING	Communication / documentation & paperwork	3					3		3				3	3	3			
INTER-AGENCY WORKING	Joint working / liaison with social care / care homes / other PCTs	3	3	3	3	3	3		3	3	3	3	3	3	3			
INTER-AGENCY WORKING	Inter-professional relationships	3	3	3	3	3	3		3	3			3	3	3	3		
INTER-AGENCY WORKING	Discharge issues / links with hospitals	3	3	3	3	3		3	3			3	3	3				
INFORMATION	Inter-professional relationships	3	3	3	3	3	3		3	3						3		

ANNEX 10

INFORMATION	Discharge	3		3	3			3							3	3		
INFORMATION	Joint-working	3	3	3	3	3			3	3					3			
INFORMATION	ICT & Access to information / barriers to IT use	3	3	3	3				3						3	3		3
INFORMATION	Documentation & paperwork / quality of information / accessing information / help seeking	3					3	3	3						3			
FINANCE ISSUES	Banding decisions	3				3	3	3	3				3	3				
FINANCE ISSUES	Allocation of resources / funding of posts	3				3	3	3	3									
FINANCE ISSUES	Uncertainty / doubt / challenges / perceived lack of transparency	3		3	3	3	3	3	3	3	3	3	3	3				
FINANCE ISSUES	Acceptability to nursing & care homes / better cash flow	3				3	3		3									3
QUALITY	Determination / how to assess quality	3			3	3	3		3	3	3	3						
QUALITY	Quality of care / nursing quality / Best Value	3		3	3	3	3	3	3	3	3	3						
QUALITY	Information & records / paperwork & documentation	3				3	3	3	3						3			
QUALITY	Discharge process	3		3	3				3						3			

ANNEX 10

COMMUNICATION	Inter-agency working / liaison with social care / care homes	3	3	3	3	3	3		3						3			
COMMUNICATION	Misunderstandings / different approaches / lack of knowledge	3	3	3	3	3	3	3	3	3	3	3						
COMMUNICATION	Advocacy / disempowerment	3	3			3	3	3	3	3	3	3						
COMPLEXITY	Lack of transparency	3	3				3			3	3	3	3	3	3	3		
COMPLEXITY	Determination process	3	3			3	3	3	3						3	3		
COMPLEXITY	Funding	3					3	3	3									

TABLE 4.6: CONTENT ANALYSIS OF SERVICE USERS INTERVIEWS

Int. = interviewee (allocated number for anonymity) All participants were from location two (PCT Two)

Identified super-ordinate category	Participants				
	Int 19	Int 20	Int 21	Int 22	Int23
DETERMINATION: aware of?	3	3	3	3	3
DETERMINATION: present at determination?		3	3		3
DETERMINATION: funding / finance issues	3	3	3	3	3
DETERMINATION: appeals etc.					
CARE: quality of care / equipment etc.	3	3	3	3	3
CARE: respondents' voices					3
COMMUNICATION: advocacy / lack of knowledge	3	3	3	3	3

